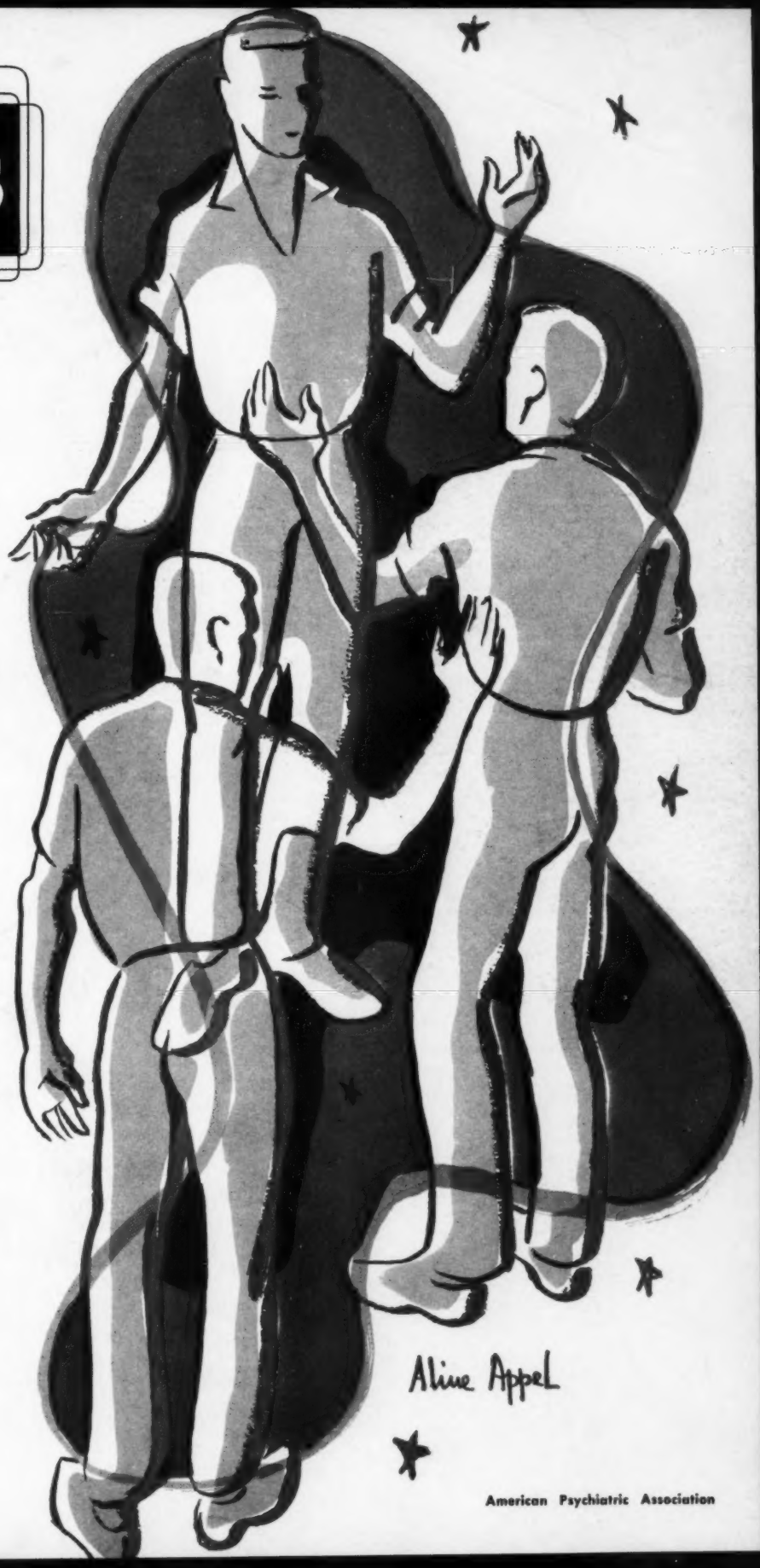
Mental Hospitals

SEPTEMBER 1958

In this issue . . .

". . . For the inmost growth of the self is not accomplished in man's relation to himself, but in the relation between men—in the making present of another self. Man wishes to be confirmed in his being by man . . . secretly and bashfully he watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed."

MARTIN BUBER



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Editor: Mathew Ross, M.D.

Chief, Editorial Dept.: Pat Vosburgh

Editorial Assistants: Elizabeth A. Keenan
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Advertising & Promotion: Phyllis Woodward, LL.B.

National Advertising Representative:
Fred C. Michalove, 6 East 39th Street,
New York 16, N.Y. (MUrray Hill 5-6332)

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CONTENTS, SEPTEMBER 1958

THIS MONTH'S COVER

Ever since MENTAL HOSPITALS was started, we have striven to improve the quality of the contents. From a slender four to eight page leaflet, it has grown to a substantial publication of 48 or more pages. New features have been added from time to time to appeal to the various disciplines represented in the operation of mental hospitals—physicians, psychologists, nurses, chaplains, social workers, dietitians, purchasing agents, supply officers, budget officers, engineers, etc.

With the current issue we are introducing a new idea on the outside of the magazine. Each month's cover will present an illustration of an inspirational quotation with behavioral references. This is the first of the new cover series, and we would welcome comments and suggested quotations from our readers.

WINFRED OVERHOLSER, M.D.

Before the fact . . . closed-ward management

THE NEEDS OF MENTAL PATIENTS

VIII. The Drive For Orientation

By PAUL E. HUSTON, M.D.
Iowa State Psychopathic Hospital, Iowa

IN HIS THOUGHTFUL ARTICLE "The Needs of Mental Patients," Dr. Walter Barton included a paragraph on a need or drive for orientation. He presents many questions involving orientation which a patient might ask, such as: "Who and what am I? Am I ill? How long must I stay here? What must I do to gain my release?"

In considering this drive we should remember that several factors affect the orientation of the patient:

1. His relationship to his physical environment.
2. His relationship to personal possessions, such as his clothing or his jewelry.
3. His relationship to other people.
4. His relationship to his self-concept, a factor composed of past experiences, particularly his interpersonal relationships.
5. His expectation of future roles, and more specifically his attitude toward discharge and return to normal living.

I shall discuss these factors as they relate to the hospitalization, management, treatment and discharge of mental patients, because the way these activities are conducted creates an atmosphere either beneficial or detrimental to the patient, and may have a decisive influence on his improvement or deterioration.

Relationship to the Hospital Environment

A decision by a patient or his relatives to seek hospital care initiates the total process of orientation. This decision may have many meanings for the patient. He may consider the hospital a place where he receives help, where he seeks refuge, or where he suffers detention. Such ideas reflect the thinking of the patient and of his family, and their attitudes toward mental illness. Unfortunately, the whole legal process of commitment, with its involvement of the courts and police, surrounds hospitalization with an unfavorable atmosphere. The patient does not control this process. Thus, social agencies, referring physicians, relatives, and others involved in commitment and referral have an obligation to help the patient think of the hospital as a therapeutic institution.

One commitment form with which I am familiar requires answers to such questions as: Relatives or ancestors insane? Has the patient shown a disposition to filthy habits, destruction of clothing, breaking of glass? Has the patient been subject to any bodily disease, epilepsy, suppressed eruptions, discharges or sores? Has restraint or confinement been employed? Such questions can hardly foster a hopeful attitude in the relatives or in the patient himself.

Relationship to Personal Possessions

The admission procedure itself can be a bewildering and painful experience for the patient. Separated from his relatives, he is divested of his clothing and jewelry, important personal possessions, and after the denuding experience of the physical examination he may receive a strange hospital gown or ill-fitting clothing.

Consider, for example, the vast difference in the way one of these activities may be carried out. With good intent, a hospital policy dictates the removal of rings from newly admitted patients to prevent loss or injury. Rings symbolize marriage, fraternal organization, etc., all with their own individual meanings. While removing a ring from the patient the nurse may remark that he might lose it. This implies irresponsibility. Or she might say that someone could steal it and injure another person. This may mean to him that he must guard himself against assaults. These are not unusual examples. The writer has seen nurses struggling with a patient to remove his jewelry while making such upsetting comments.

As a general procedure, something like the following appears to us to respect the dignity of the patient and to treat him in a manner more conducive to good management. He may choose whether or not he wishes to keep his jewelry. He is told that participating in many different activities and going to different parts of the hospital such as the occupational therapy shop, the gymnasium, the beauty shop or the swimming pool makes it easy to mislay his ring. If he desires, his jewelry will be kept in the hospital safe and returned at discharge. He will have a receipt for everything deposited there. In this way, the nurse trusts and respects the patient, a link with his past remains unbroken, recovery and discharge appear likely. All this helps establish the hospital as a therapeutic institution.

Having a nurse introduce the patient to his room, his bed, and his clothing locker helps too. We do not intend to produce a completely homelike situation in the hospital. A hospital is a special place where professional persons treat the sick. However, the patient needs a base of operations on which he can develop a feeling of familiarity. This reduces the tendency to disorientation which may be precipitated by the loss of contact with familiar things. The classic example of this disorientation is the toxic or senile patient who is worse at night when he cannot see his environment or correctly interpret the meaning of sounds.

Relationship to Others in the Hospital

On admission, the patient meets strange persons: nurses, attendants, physicians, etc., and other patients. In one sense, these persons form part of his physical environment, but they exist much more importantly as his new interpersonal environment in the hospital. The integrity of the ego and the values placed upon it by the patient depend in part upon the manner in which other persons react to him, and how he perceives them. In this unfamiliar group, the patient must be on guard to prevent damage to his self-respect. He seeks reactions from others which build self-respect or which justify his attitudes and behavior. Marked individual differences in adjustment usually become manifest in the mental hospital; these are expressions of the basic psychopathology of the patient. The depressed patient feels guilty and hopeless. The paranoid patient projects his wishes onto others to protect himself against the recognition of the personal origin of his projections. The hysterical patient seeks adulation and sympathy to satisfy his own insatiable need for affection. The dependent personality clings to others for emotional support. How will such patients be received by the patient group already on the ward? Interpersonal clashes come to light in the form of management problems on the ward, requiring decisions by the ward administrator. Some type of relationship develops quickly between each patient and all the others. Some patients cause fear, others provoke hostility, still others elicit affection, etc. What do these various experiences mean for recovery? Patients often comment, "I found my problems were not so important as those of others, and I felt better about them after I saw and talked with some of the patients on the ward who were worse off than I." Difficult interpersonal situations can become focal points for therapeutic discussion and interpretation in group or individual psychotherapy. But the significance to the patient of the social aspects of the hospital environment is often poorly understood. These interactions are in constant need of evaluation.

Ward personnel also set the stage for a therapeutic environment. It is desirable for the nurse to introduce new patients to the other patients. During these introductions she may make such casual comments as, "Mr. Smith feels much better now and soon will return home. Mr. Jones has made progress toward the solution of his troubles." Nurses and attendants caring for the patient should also be introduced.

Another useful orienting device we have employed is the patient's handbook. The patient receives this shortly after admission. It contains a greeting from the Director of the Hospital, an explanation of the hospital personnel's goal of helping the patients to recover, and a statement of various hospital procedures. The handbook also gives the location of the occupational therapy shop, the gymnasium, the coffee shop, the telephone, the mail box, the barber and beauty shop and the patients' library. In addition it lists scheduled activities such as visiting hours, religious services and times for the patient to see his psychiatrist. It tells the patient how to sign out of the ward when he wishes to go to other areas of the hospital.

Except for markedly disturbed or disorganized patients, all patients in our hospital participate in the weekly meetings of the patients' league, conducted by the charge resident and attended by the charge nurse. Shortly after admission the patient receives a copy of the league constitution. This document was written by the patients themselves in 1954 and it is amended from time to time. The patients elect a chairman for each meeting and a secretary keeps notes.

These meetings provide an opportunity to help the patients define their role as patients. Any difficulties in living conditions, complaints and suggestions regarding the various adjunctive therapies are discussed. Patients sometimes propose changes in hospital procedures. Hospital policies are interpreted. The patients also select persons from their group to work on the weekly hospital publications, to plan entertainment and other group activities, and to serve on the patients' library committee. In these league meetings highly charged personal matters occasionally emerge. The resident physician prevents prolonged discussions or deep group involvement in such matters and focuses attention on the more objective aspects of group living. The meetings improve group morale and promote a feeling of individual responsibility for group welfare.

Relation to Self

Just as contacts with others help establish and maintain a concept of self, the self concept also is based upon past interpersonal experiences. In mental illness, this aspect of the self concept undergoes profound distortions. This distortion of the self causes the patient to perceive the world differently and tends to disorient him. For example, the patient with feelings of unreality or depersonalization, or the paranoid patient who sees others as being hostile, the hypomanic patient who perceives others as more friendly than they are, etc. are types which immediately come to mind. Some of these patients have marked difficulties in adjustment within the hospital. Managing them taxes the ward administrator. Nurses and attendants can tactfully deny those grosser manifestations of psychopathology which perpetuate a distorted self concept.

Some patients need certain limits set for them. Rarely is a patient so withdrawn or so deficient in self-control that he fails completely to respond to other people. Many episodes of "acting out" behavior are products of the "locked freedom" of the ward, of the provocative stimulation by other disturbed patients, or of the excessive

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*Waggoner, R. W.: Personal communication.

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permissiveness of nurses and attendants. For example, a hypomanic patient placed on a locked ward with disturbed patients becomes much more excited and soon may increase the uproar of the whole ward.

Perhaps there is nothing more fearful to a patient than possible loss of control, for with loss of control the integrity of the ego is shattered. If this should occur, destructive or homicidal impulses might overwhelm him, or he might become the easy prey of outside overwhelming forces. On an open ward he must assume greater responsibility for his own behavior. Moving a disturbed patient to a ward of composed patients frequently quiets his disturbance. The selective assignment of the patient to wards where he can strengthen his own internal controls to a maximal degree proves beneficial. More deliberate use of various patient groups should yield much information about the value of this procedure for the self concept.

Relation to Discharge

Preparation of the patient and his relatives by discussing with the social worker and others his future employment, family relationships, and other aspects of living outside the hospital, helps establish an expectation of early recovery and discharge. Arrangements for follow-up examinations help reinforce in the patient and his family the feeling that the hospital is a place where he can return for help. An invitation to write letters to hospital physicians about himself and his progress gives him a feeling of security. If the patient is referred to a community clinic or to a private psychiatrist, he should be informed that a complete abstract of his case record will be forwarded so that he may receive whatever continued treatment is needed. The patient should also be told that the hospital physician expects him to return to a productive and useful life in the community. This expectation bolsters his ego and creates a feeling of optimism.

Our weekly therapeutic conference is a valuable administrative technique for coordinating the work of hospital personnel with patients. This is the occasion for progress reports on his patients to the resident psychiatrist from the charge nurse, the attendants, and the occupational and recreational therapists. Social workers who have had frequent contacts with patients' families also attend the conference. Here the various aspects of the patients' orientation are brought together. After group discussion the resident gives directions for the management of each patient. The conference establishes consistent attitudes and procedures toward each patient, and focuses the efforts of the group on the patient's improvement and discharge.

Devil's Dictionary

By Dr. WHATSISNAME

From our residents' lounge, the other day, came a mish-mash of morbid words: anal . . . aggressive . . . guilt . . . acting out . . . genitals . . . hostile. The psychiatric lexicon is indeed loaded with words which make the ordinary fellow blush or bristle. Sometimes the patient must think we look down our noses at him. How else is he to react to words like "infantile" or "aggressive"?

Whaddya mean . . . infantile!

Whatever meaning they convey to the sophisticate, they are scolding words to the average man. To say that a thought is unconscious is, to innocent ears, an insult. The word "ego" may be a special noun to you, but to the uneducated it means "conceit." Such terms as "death wish" and "sadistic" may be everyday currency in our residents' lounge, but they sound positively morbid to the unschooled. To the cognoscente, everyone has a tincture of homosexuality. But to the uninstructed, that's a fighting word. Lightly we toss off such words as erotic, incestuous and castration. These terms, indeed, have become so shopworn that they have long since lost their impact.

What a strange vocabulary we psychiatrists have! Probing the depths of the mind should surely reveal well-springs of idealism, courage and nobility. If lower than angels, we are higher than beasts, using those adjectives "lower" and "higher" in the conventional sense. Yet somehow, the idiom of psychiatry seems to the average man, to be overloaded with words of insult, reproof or gloom. How odd it is, that we who should be the keepers of the richer life, we who should hold the keys to the door of happiness and the answer to the mystery of adjustment, we, of all people, should have so unattractive a glossary!

Achieving a Therapeutic Ward Setting*

By DANIEL J. LEVINSON, Ph.D., Director
and MYRON R. SHARAF, M.Ed.

Center for Sociopsychological Research
Massachusetts Mental Health Center
and Harvard Medical School

EVERYONE AGREES that the ward setting is an important part of the mental hospital program. And there is, no doubt, equal agreement that much needs to be done if the ward is to play its full part in promoting patient recovery. The general level of ward care and treatment depends, not primarily on specific techniques but on organizational and human factors: the hospital social structure; the expected roles of physician, nurse, and patient; the personal orientations and capacities of the individuals involved; and so on. These are the factors we aim to discuss.

In recent years, the nature and general level of patient care has been stongly influenced by two developments. The first of these is the growing effort to "humanize" the hospital, to make it more democratic in structure, warmer in spirit, richer in meaning. Closed wards have been opened, various degrees of patient government have been introduced, recreational and work facilities have been improved, and the patient's general status in the hospital has been raised. Ordinarily these changes have been initiated as matters of policy by the administrative-medical authority, but they have been carried through chiefly by non-medical personnel in the nursing and the "ancillary" departments. These policies and modes of intervention are not, for the most part, intended to induce major depth-insights or restructurings in the patient. Their aim, rather, is to provide him with opportunities to learn and gain greater self-mastery through constructive activities and personal relationships. Terms such as "milieu therapy," "total push treatment" and "sociotherapy" have been used for this development. There is continuing controversy as to whether it should be considered "therapy" rather than "care" or "management."

A second major development has been the assimilation of dynamic psychiatry within the hospital. Psychotherapy has become the predominant treatment of choice within our best known, active-treatment hospitals. These hospitals are almost always psychiatric training centers where residents receive an important part of their education, preparatory, very often, to entering the private practice of psychotherapy or psychoanalysis. It is to be noted that whereas sociotherapy has been an indigenous development within mental hospitals, psychotherapy is, so to speak, an import, transplanted into the hospital from outside private practice largely with neurotic patients.

The two developments, psychotherapeutic and sociotherapeutic, have much in common and are in many ways mutually supportive. Dynamic psychiatry has helped supply a theoretical rationale and a stimulus for many of the ongoing changes in social structures and ward intervention. In principle, it is expected that ultimately the efforts of the psychotherapist and of all other hospital personnel can be coordinated into a unified treatment program.

At the same time, hospitals that have sought to integrate psychotherapy and sociotherapy have been confronted with new treatment problems and inter-staff tensions. The resolution of these difficulties will, we believe, require new modes of training for individual staff members, as well as some reorganization in hospital structure and inter-staff relationships.

Division of Function Traditional

One major difficulty stems from the fact that the two types of treatment are usually carried out by different professional groups. That is to say, there is a legitimized division of function so that psychiatrists (and occasionally psychologists and social workers) are responsible almost exclusively for psychotherapy, while nurses, occupational therapists and the like are concerned primarily with the patients' day by day living in the hospital community. This division of labor is, of course, a carryover from the model of the general hospital, wherein the physician prescribes specific treatments and the nurse acts as medical lieutenant and general housekeeper.

Whether this organizational model is an appropriate one for the mental hospital is still an open question. Certainly there are plausible arguments for the traditional division of function. Psychiatric nurses continue to receive their primary training in the general hospital and frequently find the general medical conception of the nursing role the most congenial one. Moreover, the psychic roots of severe mental illness are deep and widely ramified. To understand and treat such illness involves a complex learning process that is beyond the capability or educational level of many hospital workers. It is important to give patients the respect, encouragement and control required in a humane milieu, but additional training and skills are required of the psychotherapist. The process of helping the patient gain insight into his illness and its causes, such an essential feature of psychoanalysis and related psychotherapies, requires much more than humaneness and is perhaps best reserved for those few who devote many years of hard study to it.

So run the arguments for maintaining a relatively

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* *This paper was presented in a symposium on the mental hospital, at the 1956 Convention of the American Psychological Association.*

strict division of function. Unfortunately, the division tends to create a serious gap between psychotherapy and sociotherapy. In hospitals where psychiatric residents have the main responsibility for psychotherapy, the residents tend often to become overly preoccupied with their psychotherapy cases and to neglect other patients on their case load. Residents are criticized for getting lost in dynamics and being indifferent toward, if not contemptuous of, everything besides psychotherapy and the handling of special emergency situations. The psychotherapist often knows little about his patient's behavior on the ward. He is thus hampered in making decisions about patient management, discharge, etc., and he cannot make available to ward personnel any of the insights derived from psychotherapy. Frequently the psychotherapist grants special requests to his patients without consulting ward personnel and these favors cause difficulties that might be avoided by better communication and more collaborative decision-making.

Ward personnel, on the other hand, are often uninformed and unskilled in psychodynamic theory and practice. They may be too quick to control the patient's symptoms through the use of seclusion, drugs or electric shock, and they are often intolerant of the psychotherapist's time-consuming efforts to work through the patient's anxieties in psychotherapy. The correction of these strains requires, of course, that ward personnel be given more training in psychodynamics and in the "transference" aspects of ward relationships.

Authority and Responsibility Ambiguous

In addition to the foregoing problems of training and communication, there are problems that stem from the structuring of authority and responsibility in the hospital. The usual rule, based on the concept of medical responsibility, is that the resident is responsible for the individual patient and the head nurse is responsible for maintaining the ward. Since much of the patient's life is spent on the ward, there is considerable ambiguity as to who has the legitimate authority for making decisions governing the patient's everyday hospital life. Even when such decisions are nominally the province of an administrative psychiatrist, the nurse frequently induces a particular decision without having the legitimate authority to do so. The pat answer to this problem is that the staff comprises a team in which all opinions are honored. However, staff differences in training and perspective, and inequalities in power, often lead to unilateral, poorly considered decisions.

Various attempts are being made to bridge the gap between psychotherapy and sociotherapy. One approach has been to eliminate altogether the division of function between ward personnel and psychotherapist. That is to say, each staff member has psychotherapeutic (interpretation-giving, transference-handling) responsibility as well as recreational, housekeeping and other responsibilities for his patients. This approach has perhaps been carried furthest in a few children's residential treatment centers where "counselors" carry the entire burden of care and therapy and receive intensive supervision on each case. Treatment takes place entirely within the context of daily living and no office psychotherapy is scheduled.

A rationale for this procedure is given by Bettelheim and Wright in their article "The Role of Residential Treatment for Children", which appeared in the *AMERICAN JOURNAL OF ORTHOPSYCHIATRY:*

"In our experience, residential staff members can accept and deal therapeutically with the threatening behavior of extremely regressed or violently acting-out children only if the workers are also responsible for all aspects of therapy. Without the rewards this implies, the worker's experiences with the children cause them to react in ways that are bad for both . . . They can be avoided only if the staff members know it is their responsibility, and only theirs, to help these children, if they receive all the narcissistic and interpersonal rewards that derive from being the children's main therapists."

Social Aspects Valuable to Psychiatrist

The synthesis of "care" and "therapy" functions within a single staff role has by and large not been attempted in medical hospitals for adult patients. However, certain mental hospitals, particularly the smaller, training-research centers, have attempted to "bridge the gap" in some measure by giving the ward personnel greater training in dynamic psychiatry and by giving psychiatrists greater training in the social aspects of hospital lfe. If nurses are to respond in differentiated ways to different patients, then the nurse must come increasingly to grasp the meaning of each patient's behavior and its emotional impact on herself. And those patients who are not in formal psychotherapy might benefit considerably from relationships with nurses who can, in the words of a G.A.P. Committee, make "therapeutic use of the self." Some progress has already been achieved in certain hospitals.

Similarly, various training centers are providing their psychiatric residents with increased training in "milieu therapy" and related matters. The resident is expected to become a more active and participating member of the hospital community. In the process, he can presumably gain a broader perspective on his own individual patients and on the collective patient society. He can intervene more wisely in disruptive, individual and group episodes. He can give more to and gain more from the personnel who live so intimately with patients. And he can perhaps contribute to the formation of new modes of hospital organization and patient care.

A final argument for this approach is that an understanding of social processes will benefit a psychiatrist in his post-hospital career. Many functions of ward personnel are analogous to those performed by teachers, parents, and others in the community. To understand the stresses and adaptations of hospital workers, and to learn how to modify their behavior in a therapeutic direction, is a valuable experience for anyone interested in applying psychiatric knowledge on the broad social scene.

No setting is better suited than the mental hospital for giving evidence of the interweaving of psychodynamic and social processes; thus, apart from practical considerations, the hospital has a great deal to offer, with regard to theory and research, in the further development of dynamically oriented social psychology.

Despite the progress that is being made, it is clear that there are serious obstacles hindering the integration of viewpoints and roles within the hospital. There is much that we need to know about the social and psychological forces operating to maintain the existing structure as well as those operating to change it. We have been able in this brief space to indicate only a few of the obstacles to change: the patterning of the mental hospital structure after that of the general hospital; the concept of medical responsibility; the assumption of a dichotomous distinction between "care" and "therapy"; the fact that most residents are strongly committed to the role model of psychotherapist or analyst in private practice; the acceptance by most nurses of a traditional nursing role; and so on. Those of you who work in large hospitals will no doubt point out even graver obstacles: shortages of personnel and money; problems of getting fundamental concepts across to unreceptive minds; not to speak of the sheer size of most hospitals and an architecture designed essentially to keep people apart and under control.

Still, there is room for hope. We live in a time of quiet revolution in which industry, education, penology and other social institutions have made considerable progress in dealing with similar organizational and human problems. As mental hospitals lose their insularity, they may learn from and contribute to this historical trend.

Say When!

The installation of a juice dispenser in one department of the VA Hospital at Fort Lyon, Colorado has resulted in a distinct improvement in the administration of tranquilizing drugs. Liquid chlorpromazine is mixed with fruit juice and dispensed from the refrigerated unit which is similar to those used in restaurants. Ward personnel call it the "juice bar" and patients, picking up the light attitude, call the mixture, "Kick-a-poo joy juice." The change of atmosphere resulted in such improved ward morale that patients now show eagerness to take the drug rather than resistance.

FRED HERRING, Ph.D., Senior Psychologist
RUTH E. MARTINEZ, R.N. Head Nurse

USES OF THE PAST

III. Results of Moral Treatment

THE HIGH DISCHARGE RATES claimed for the moral treatment era have been largely discounted by modern psychiatry because no systematic follow-up studies were ever published. Actually, the course of mental ills, left "to the resources of nature," still remains undetermined!

It is, therefore, a matter of some interest to present the results of one follow-up study done in the 19th century, by Dr. John G. Park, Superintendent of the Worcester State Hospital, who reported the mental conditions of patients over a period of 35 to 60 years after their discharge. It suggests that the trend is in the direction of recovery more frequently than is generally recognized.

A. 635 patients were mentally well or had died mentally well during the 35 year to 60 year post-discharge period—fifty-four per cent of the original 1,173 included in the study. Of these 635 patients, 568 or forty-eight per cent of the original 1,173, had never had a relapse.

B. 349 patients—thirty per cent of the original 1,173—were mentally ill or had died mentally ill.

C. 189 patients—sixteen per cent, could not be located.

It should also be pointed out that the number of patients who relapsed and were readmitted to a mental hospital (or admitted to an almshouse) was 210—less than twenty per cent of the original 1,173 patients.

Other statistics of the time show treatment results of approximately the same order. Of 1,104 patients admitted to Butler Hospital, for instance, from 1847 to 1866, Dr. Isaac Ray reported 720, or sixty-six per cent, recovered and improved. Dr. Park himself reported 5,409 recovered and improved out of 8,204 admitted from 1833 to 1855—a proportion of sixty-six per cent.

Perusal of the annual reports of the 1830's and 40's of Hartford Retreat, Brattleboro Retreat, Bloomingdale Hospital, McLean Hospital, Utica State Hospital, Concord State Hospital, Augusta State Hospital and others reveals similar results. Where the results are reported on patients ill for less than one year, the figures for recovered and improved average about seventy-five per cent.

These statistics strongly support the following quotations from Pinel's "Treatise on Insanity" (1806).

"The laws of the human economy considered in reference to insanity as well as other diseases, impressed me with admiration of their uniformity, and I saw, with wonder, the resources of nature when left to herself, or skillfully assisted in her efforts. My faith in pharmaceutic preparations was gradually lessened, and my skepticism went at length so far, as to induce me never to have recourse to them, until moral remedies had completely failed . . . .

". . . Attention to these principles of moral treatment alone will, frequently, not only lay the foundation of, but complete a cure: while neglect of them may exasperate each succeeding paroxysm, till, at length, the disease becomes established, continued in its form and incurable. The successful application of moral regimen exclusively gives weight to the supposition, that, in the majority of instances, there is no organic lesion of the brain nor of the cranium."

J. SANBOURNE BOCKOVEN, M.D.

Day Camp in Connecticut

JOHN F. BERGAN, Chief of Public Relations
Connecticut State Hospital, Middletown

THE CASUAL, carefree atmosphere of a day camp was the setting last summer for a new experience in living for a group of women patients from the continued treatment wards of Connecticut State Hospital. They ranged in age from 16 to 70 years, most of them long-term schizophrenic patients who had no friends and few interests.

The campsite is located on the grounds a mile from the hospital proper and set apart by low hills. Under the direction of Mrs. Virginia Holmberg, O.T. director, the wooded six-acre valley was transformed into a camp in 1957. Crews from the Industrial Shop cleared weeds and brush from the site, built picnic tables, fireplaces, a canteen counter and a storage shed.

About 150 women use the camp each summer. They are taken in groups of 24 on two consecutive Mondays and Wednesdays, accompanied by an occupational therapist and an O.T. aide. The hospital hopes eventually to have sleeping quarters at the camp so patients can spend two full weeks there.

The Camping day begins when the women tumble eagerly from the bus and assemble around the flagpole for the flag raising ceremony. Then they are divided into six teams of four, identified by colored badges; each team is assigned specific work and play activities.

During the morning the women play horseshoes, badminton, softball and volleyball. Those who prefer less strenuous recreation may take nature walks or sketch. Everyone is urged to take part in the planned events but is under no pressure to do so. Each camper is given a canteen card to make eight "purchases" of candy or sundries whenever she wishes throughout the two weeks.

Following a mid-morning snack of fruit juice and crackers, the campers can smoke and relax until lunchtime. A hot lunch is served them at Silvermine Cottage, the hospital's farm dormitory, which is a short walk over the hill.

After lunch and a 1½ hour rest period, the women are ready to resume their games or work on arts and crafts projects until it's time to start preparing supper. Suitable sports attire for camp activities was donated by local residents in response to an appeal from the hospital's director of volunteers, Mr. Charles Umba.

Supper is made over the campfire, and everyone pitches in to help. Teams are assigned to prepare and cook the food, set out plates, and later to clean up the campsite. Many patients who are habitually wary and withdrawn are, by their second day at camp, "old timers" who eagerly take part in tasks and games.

The day at camp ends with retreat ceremonies at the flagpole and a songfest around the campfire. After the fire dies out the campers gather up the supplies and climb aboard the waiting bus for the trip back to the hospital. When the bus enters the hospital grounds they are still singing—and ready for bed, even if it is only a single cot in a big hospital ward.

Hospital Trains Own Child Care Workers

By JOHN RICH M.D., Ph.D. Director,
W. T. LAWSON, M.S.W., Chief Child Care Worker,
and EILENE McINTYRE, B.A., B.S.W., Supervisor
Thistletown Hospital, Ontario, Canada

THE THISTLETOWN HOSPITAL is a psychiatric facility for children, the first of its kind in Canada, which has as one of its prime functions the training of staff for similar units. Even before its opening in January 1958, this teaching hospital found itself faced with the problem of designing a course to train child care workers or "Counsellors" to staff its own wards and provide the day to day care of the children.

Accordingly, a course of orientation and preliminary education was outlined for the three months immediately preceding the opening of the hospital. Students were recruited from a variety of backgrounds and professional disciplines, and entered training at the rate of approximately ten a month from October through December, 1957. In educational attainment they ranged from those with the equivalent of one year of college to those with university degrees, and some with Master's Degrees. They included nurses, hospital attendants, nursery school workers, teachers, social case workers and group workers, recreation workers, and persons with no professional training. They ranged in age from 22 to 50 years.

Courses Tailored to Student Needs

Orientation courses were tailored to suit the different needs and backgrounds of the students. Basic theoretical classes in child psychology and development were provided for those who lacked educational training in these areas, and additional courses in psychopathology and child psychiatry were given to all students by the psychiatric staff of the hospital.

Students without previous institutional experience were placed in one of several childrens' institutions where they gained practical knowledge working with children and learning their routines and special activities. This was combined with observation, lectures, and discussions led by staff members of the cooperating facilities. Placements averaged two to four weeks in an institution for mental defectives or a hospital or residential setting for disturbed children. One settlement house in downtown Toronto and a school for retarded children provided opportunities for students to work under staff supervision with small groups of children in games, arts and crafts, class room and informal play activities. All placements were preceded by and followed up with group discussions involving staff members of the agencies in question.

Training in specific skills included active sessions with participation by all students in games, music, dancing, etc., led by experts in these fields or by members of the student group. Opportunities were provided to practice using these skills with groups of children.

In order to familiarize students with the various agencies and organizations serving children in the Toronto area, visits were scheduled with periods allotted for discussions with staff of these centers. When time precluded visiting certain institutions, their staff members were invited to speak to the students at the hospital and describe the services provided by these agencies.

Group Discussions Prove Valuable

Discussion meetings were held frequently throughout the training course and students were asked to make regular evaluations of the content and organization of the training program. This was supplemented by individual interviews. These group discussions were felt to be extremely valuable and helped to give the course a necessary flexibility in aim and in sequence. The group discussion process in itself was used both to increase individual student's self-understanding and to strengthen group morale. Senior staff members met frequently with the students to discuss theoretical and practical aspects of their respective duties. In addition, information-giving sessions were held to answer specific questions raised by the students.

This preliminary program was necessarily limited in character because of the time factor and the difficulty of recruiting during the three months' period. However, students and staff alike expressed the opinion that the course was successful in realizing its objectives.

With the hospital now open, the training has begun to follow a slightly different line with primary emphasis on in-service experience with children. The student's time is allotted so that in a fourteen day period he spends seven days on the ward, three days in formal training sessions, and four days off.

On the ward the student works an eight-hour shift. Under the direction of a trained ward supervisor he

shares responsibility with three or four co-workers for the physical care and play activities of eight children and keeps records on their behavior.

Formal training sessions include group discussions with the Chief Child Care Worker and Ward Supervisors on the handling of individual children, routines, ward situations, planning programs, etc. (4 hours); weekly case conferences wherein patients to be admitted during the following week are presented by the staff of the Outpatient Department (3 hours); daily ward meetings attended by staff on duty on the ward (3 hours); individual sessions with ward supervisors (1 hour); discussions with staff psychologists, social workers, teachers, and occupational therapists on the responsibilities and problems of their respective departments, with special reference to individual children and/or their parents (3 hours). Reading is assigned in connection with particular training sessions and to give a general background. Guest speakers are a regular part of the course.

The program is new and is in constant development. It is periodically revised in accordance with changing needs, and as new units of the hospital are opened, courses are modified.

Students now in training include thirty child care staff and two members of the nursing staff of the hospital.

Dental Hygienist Instructs Retarded Children

At the Walter E. Fernald State School in Waverly, Mass., classes in dental hygiene and related health subjects are taught by the school's dental hygienist, Miss Charlotte M. Collis. In addition to toothbrush drills and discussions of good health practices, the classes feature educational movies and slides, along with quiz games and other class participation activities useful in teaching good dental care. After a year of work, Miss Collis says she finds the enthusiastic cooperation and appreciation of the children truly rewarding.

PORTABLE ELECTRONIC PIANO BRINGS MUSIC TO THE WARDS

By WINIFRED D. HANSEN, Director of Music Therapy,
C. F. Menninger Memorial Hospital, Topeka, Kansas

THE MAJOR PART of our hospital's milieu therapy program is conducted in shops a small distance from the hospital building proper, and most of the patients can leave the hospital to go there. Many, however, are too disturbed to be permitted to leave the hospital building and a small crafts shop is located on the ward for the acutely ill. While this shop is well equipped for most activities, it lacked a piano, since a conventional piano would take up too much space. It would be difficult, moreover, to work with patients individually as several persons are often in the room at one time; the noise of playing would at times be objectionable.

These difficulties were overcome with the electronic piano, which is of small size, portable and has an earphone and volume control attachment. Compactness permits its use in areas of limited space, such as the small crafts shops or in patients' rooms. The legs can be removed and placed in the keyboard cover so the instrument can be carried like a large suitcase (folded dimensions: 39″ x 22¼″ x 8″) and used in other buildings and areas (even out of doors if electricity is available). When others would be disturbed by the sound of the piano, the earphones and volume control permit a patient to play or practice without being heard by others. When not in use it can be stored in a small area.

In addition to making it possible to bring more music therapy activities to the ward of acutely ill patients, the presence of the piano on the ward has stimulated many patients who played in the past to want to play again. With some patients, it has aroused interest to study.

The piano can be used either as a solo or accompanying instrument. Its sound is of a quality described as being "between that of a piano and harpsichord", and the action of the key is said to be "more like that of an organ". The sixty-four note keyboard is of standard height. A sustaining pedal is auxiliary equipment. The electricity the piano operates on is 110 volts, 60 cycles, 60 watts A.C.

Other features which make the instrument still more versatile are an input jack for a record player and an output jack for an extension speaker or additional amplification equipment. Cost of the piano—including the auxiliary equipment of earphones, sustaining pedal, portable leg kit, and bench—is about $400.

Conference on Volunteer Services To Psychiatric Patients

THE EXISTING STATUS and future possibilities of volunteer services to mental patients in hospitals and other community facilities were explored in a five-day conference held in Chicago June 12-17 at the Edgewater Beach Hotel.

The Conference on Volunteer Services to Psychiatric Patients took place after a year of preparation. It was administered by the American Psychiatric Association and financed by a grant of $50,000 from the National Institute of Mental Health, U.S. Public Health Service. Four other national organizations co-sponsored the conference: the American Hospital Association, the American National Red Cross, the National Association for Mental Health, and the Veterans Administration. More than 60 persons took part in the meeting, including state commissioners of mental health, superintendents of mental hospitals, coordinators of volunteer service programs, executives of national voluntary service organizations, hospital chaplains, occupational and recreational therapists, and staff members of mental health societies.

Dr. Daniel Blain, then Medical Director, and Dr. Harvey J. Tompkins, Chairman of the A.P.A. Committee on Standards for Hospitals and Clinics, were Co-Chairmen of the Conference.

This was a "working conference" devoted essentially to a critical evaluation in small groups and plenary sessions of the reports of four preparatory commissions. The objectives of the preparatory work were to assemble all possible information about existing volunteer programs including, for example, how many volunteers work in what kind of hospitals and community agencies; what kinds of work they do; what is judged to be their unique contribution over and above routine assistance to staff members; what special qualities volunteers have; how they fit into the administrative operation of the hospital; how they are recruited; and what potential contribution they might make in the context of the growing integration of the mental hospital and the community, specifically as regards assistance to mentally ill people before and after hospitalization. The findings of the four preparatory commissions were considered by the full membership of the Conference.

Existing Programs Surveyed

Much discussion centered on the findings of a comprehensive questionnaire which was sent to psychiatric institutions of all types—Federal, state and private mental hospitals and state and private schools for the mentally retarded. This study was intended to gather basic data about existing volunteer programs, to ascertain their accomplishments, goals and limitations. While the study did bring out many useful facts and opinions about voluntary service, the consensus of the Conference was that the material reveals trends rather than high precision data. This was probably because most hospitals have had volunteer programs for a relatively short time and these programs are growing and developing so rapidly that it is difficult to secure accurate statistical information.

Certain trends are very apparent. The 43,000 regular and occasional volunteers who work in psychiatric institutions are found to be working in nearly all departments, performing a great variety of tasks. The majority are reported by recreational and occupational therapy departments, since many groups come in to provide entertainment, special parties and such. There are nevertheless, a sizable number of regular volunteers who work in a direct person-to-person relationship with patients, and others who assist the staff with clerical work and administrative duties.

It was apparent from the discussion that the fact-finding group had uncovered the existence of many unusual types of volunteer contribution, which might well be developed as the programs continue to expand and mature.

Administrative Policies

There was general agreement that apart from top administrative acceptance and support, a director of volunteers is the main factor in assuring the success of a volunteer program. Careful administrative pre-planning is essential. Volunteers must be clearly informed of the policies of the hospital regarding their work and the over-all volunteer program.

Discussion of costs brought forth the comment from one participant that a volunteer program probably offers the "best bargain for the hospital dollar." Certain recruitment and training expenses are inevitable, as is an increase in administrative overhead. Insurance coverage was found to vary in different organizations and in different sections of the country. It was suggested

that a thorough study be made of possible insurance plans to cover volunteers and that certain groups, including the American Psychiatric Association and the Council of State Governments, might examine the question of Workmen's Compensation if the volunteer is injured on the job.

Members of the Conference were agreed that volunteers can be used anywhere in the hospital depending upon their qualifications and personalities, but that as a policy they should not replace paid personnel. It was suggested that in general volunteer services should be used to meet the needs of the patients rather than the needs of the hospital.

Recruitment and Training

The discussion of recruitment and training of volunteers also laid emphasis upon meeting the human and material needs of the patients. However, the needs of the volunteers themselves were also considered and several recommendations were made concerning recognition of volunteer services. Such recognition, it was pointed out, should include not only certificates and awards, but sincere appreciation by the hospital administration of the volunteer's contribution, and increased responsibility where individual ability and interest make it desirable.

Good training and supervision were declared vital to a good program. The placement of an individual where he can do the most good and thus get the most personal satisfaction is mandatory. In general it was decided this should be the responsibility of the Director of Volunteers, although it is also important that the heads of other departments wholeheartedly accept the assignment of volunteers to their specific areas.

Members of the Conference agreed that the quality of volunteers is more important than mere numbers, but emphasized the fact that recruiters are not limited in their search for quality volunteers. All segments of the community are potential resources for first-rate people. Mentioned as untapped "volunteer pools" were labor unions, college students, personnel officers in industry. It was suggested that the latter often know of retired people (especially men, for whom there is a great need) who would be glad to offer time and talents.

Voluntary Services in the Community

If it is true that hospital volunteer programs are still in the stage of growth and expansion, community programs of service to psychiatric patients are in an even earlier stage of development. The preparatory Committee which worked on this topic discovered not so much a lack of action in this area as an indication that community programs are still in their formulative stages

and their sponsors find it difficult to outline exactly the scope of their activities. There are, however, many examples of dynamic direction and eager participation.

The Conference pointed out that a volunteer who works with psychiatric patients in the community will have a better knowledge of the subject if he has already had experience in a psychiatric facility. Further, the group felt that once a hospital has started a volunteer program, it should work actively to extend this program into the community, thus achieving two things: a continuity of treatment and help for the patients, and a group of experienced volunteers in the community.

These community volunteers can do many things: they can establish a therapeutic relationship with ex-patients and their families; they can help community facilities to assist ex-patients in their readjustment to community life; they can assist in discovering job opportunities (although the Conference felt that job placement and follow-up should continue to be the responsibility of paid professional workers); they can do a great deal, both directly and indirectly, in educating the general public about mental illness; finally, they can do much to implement social and legislative action on behalf of the mentally ill and the mentally retarded. It was mentioned parenthetically that community programs for the mentally retarded seem to be better organized than do those for the mentally ill.

Book and Public Meeting Planned

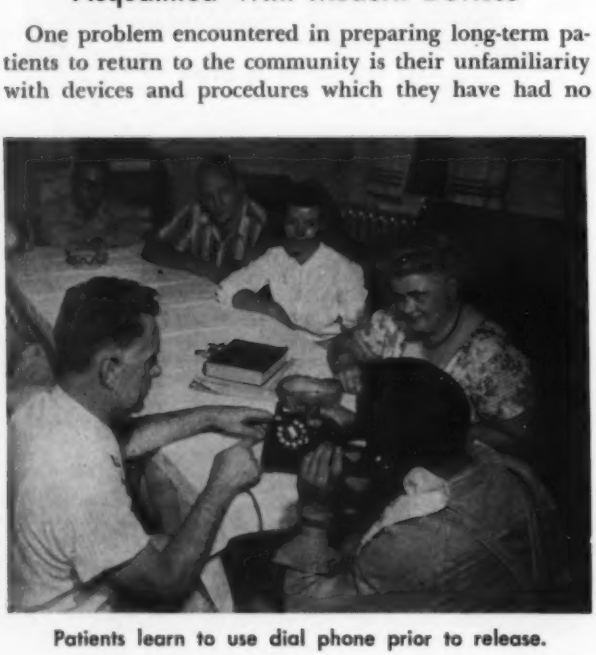
At the final session of the Conference a six-man Editorial Board was appointed from the membership to work with Mrs. Natalie Spingarn, a professional writer, to prepare a book based on the Conference findings. The two Co-Chairmen, Drs. Blain and Tompkins, will represent the A.P.A.; Dr. John Blasko, the Veterans Administration; Miss Mary Mackin, the National Association for Mental Health; Mrs. Katherine Mills, the American National Red Cross; and Mrs. Viola Pinanski, the American Hospital Association. Mrs. Ruth Knee of the National Institute of Mental Health will serve as ex-officio consultant to the Editorial Board. Until the publication of the book the preparatory materials and documents containing the deliberations at Chicago will remain the property of the Conference and as such will be released to individuals only upon approval by the Editorial Committee.

The Steering Committee, representing the five co-sponsoring organizations of the Conference, will continue in existence to consider a follow-up public meeting based upon the findings of the Conference. It is anticipated that representatives from all interested agencies will be invited to attend this meeting, which will feature some national speakers but will center mainly on audience participation. The basic purpose of the meeting will be to implement the work of the Conference on Volunteer Services to Psychiatric Patients, and to promote enthusiasm and publicity about the volunteer movement in this field.

It is planned that the public meeting will be held sometime within the next year in conjunction with the publication of the book. A definite date will be announced as quickly as possible.

Pre-Discharge Patients Acquainted With Modern Devices

One problem encountered in preparing long-term patients to return to the community is their unfamiliarity with devices and procedures which they have had no opportunity to use during their hospitalization. Many have never seen dial telephones or other modern household equipment, or learned to use bus transfers, for example. At Topeka (Kans.) State Hospital, the preparation of long-term patients who have recovered sufficiently to be released to boarding homes includes familiarizing them with such details of everyday living.



Patients learn to use dial phone prior to release.

This type of orientation was started when one social worker began meeting on the ward with small groups of patients for whom she was making release plans. As she talked about life outside the hospital, other patients listened in and gradually the whole ward was involved. Now the weekly meetings are observed by the psychiatrist and the adjunctive therapist for the section, and by the ward aides.

Besides having demonstrations of equipment and discussions about life outside the hospital, the meetings occasionally feature a boarding home operator to explain how the homes are operated. This ward also has on the wall a map of Kansas on which the patients follow the progress of their discharged wardmates. Each dischargee is represented by a flag pinned at the town where he is living, and the patients take great interest in seeing the flags go up on the map and in hearing about how the dischargees are getting along.

MRS. LETHA SWANK
Director of Public Information

Aide Training Courses Include Field Trips

Field trips by bus to other institutions in the state are part of the inservice training for psychiatric aides at Parsons (Kans.) State Training School. These have not only proved educational and entertaining but have established good inter-agency relationship. The training classes also feature guest lecturers when available and at least 50 films, slides and other visual aids are shown. Besides the three class instructors—two registered nurses and a psychiatric aide III—30 staff members serve as scheduled lecturers.

LEONA D. DYE, R.N., Director
Psychiatric Nursing Education

"Household Aides" Assist in Patient Care

The people who clean up the building for the patients are entitled to just as much status and consideration as anybody else on the team. This is the philosophy which underlies our system of "divided authority" in the Dix Pavilion, St. Elizabeths Hospital, whereby the head nurse is responsible for the cleanliness and sanitation of the wards, and the head housekeeper for the rest of the building. "We're not just cleaning women; we're working with the rest of the staff to get sick people well," is the way several of our household aides have expressed it to us.

Our household aides are included in ward personnel conferences, parties and other activities. They are invited to voice their opinions. They are given every opportunity to show initiative, and this they have done. However, we take care to limit the responsibility these girls are expected to carry. Our theory is that they can work more effectively if their personal security is not threatened by an overload of patient responsibility.

However, five of the aides have requested consideration for promotion to actual patient care and one has already been promoted to the status of nursing assistant. All of them fulfill the household duties without friction among themselves, the nursing staff or the patients, and most add a great deal of personal investment in the patient care program.

Before the Dix Pavilion was opened, a mass meeting was held of all personnel—doctors, nurses, attendants, household aides, social workers, activity therapists, physical therapists and pastors of the three major faiths. Each member was introduced and his role explained.

When patients came in, each ward was staffed by a head nurse, two attendants, and one household aide. Some of the household aides had to be dropped because they were unable to meet the demands, but our present group functions splendidly. When I talked with them recently, I found they had added a new concept to patient rehabilitation. "If we keep the wards clean and sanitary," said one, "this will be an incentive for the patients to keep their homes just as neat and pretty as Dix Pavilion when they go home."

L. LOUISE M. WADE, R. N.
Head Supervisor

Letters and Clinical Notes Dictated by Telephone

The professional staff at the Nebraska Psychiatric Institute, Omaha, needs dictating equipment immediately available in order to keep correspondence and patients' clinical records as up to date as demanded by our service and teaching needs. It would, however, have been very expensive to supply individual dictating machines, which would, moreover, be used only a small percentage of the time by each staff member. Instead, the Institute had three Ediphone Voicewriter remote recording units attached to its automatic dial telephone system.

The dictating units are located near the PBX board and are serviced by the operator. The stenographic section is located in an adjoining room; consequently there is no delay in delivery of rush work to the typists.

The dictating process is simpler than using regular dictating machines. The telephone dial is used to connect the dictator with the machine, to start and stop dictation, to mark corrections, to mark the end of dictation, and for play back. Typists prefer dictation from the remote machines to dictating machines principally, we believe, because the dictator holds the telephone in a natural position while he tends to become careless with a microphone.

The system does have shortcomings, but we recommend its use for letters and relatively short reports. For staff members who intend to dictate for an hour or more, we have available a limited number of individual machines.

JOAN KANE
Supervisor, Medical Records

Spring Grove Studies Medical Records

A three-year program of investigative studies into the effectiveness of medical records in state hospitals is under way at the Spring Grove Hospital in Baltimore under a grant from the National Institute of Mental Health. The type and content of records and methods of their administration are reviewed successively from the standpoint of their usefulness to each division or department of the hospital. Investigators work with an Advisory Committee consisting of representatives from all of the state hospitals in Maryland and from the state authority.

It is anticipated that this research will produce improved methods of record control which will make medical records more valuable to all disciplines concerned with the care of the mentally ill in state hospitals.

Correction—Private Hospital "Approved"

In the June issue of MENTAL HOSPITALS, we published a list of hospitals "Approved" and "Conditionally Approved" by the Central Inspection Board.

The Board has requested us to make a correction, and to add the name of the Ingleside Hospital, a private institution in Cleveland, Ohio, to the "Approved" list. This brings the total of "Approved" hospitals to 29.

Book Reviews

CLOSED RANKS—An Experiment in Mental Health Education By Elaine Cumming and John Cumming. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts. $6.50

A sociologist wife and psychiatrist husband teamed up to write this book. In clear simple prose, they relate the story of a six months experiment in mental health education conducted in a small town in Saskatchewan.

The study was designed to investigate to what extent and in what directions attitudes toward mental illness are changed by an intensive educational program. Mental illness was held to refer to people sick enough to require care in the hospital.

The site of the study was two small rural towns 150 miles apart. The experimental town had 1500 people with about 450 homes, was settled, stable, and had a fairly provincial homogeneous population. It was considered a conservative town. The control community was somewhat smaller but quite similar to the experimental town. The researchers planned to administer attitude questionnaires to every adult in the experimental town before and after the educational program and to conduct a number of interviews. About 100 adults were to be sampled similarly in the control town.

The educational program was introduced through local contacts and town leaders and gradually moved out to local organizations and social institutions such as schools and churches. The newspaper and radio were used regularly both to publicize the program to win local support, and to present educational material. Lectures, informal talks, discussion groups, films and informal contacts with townspeople were all utilized to spread information concerning the mentally ill.

At the beginning of the experiment, the Cummings found the town to be friendly, receptive, interested, cooperative and willing to accept the program on trial. A six person team carried out 100 interviews, meeting relatively few refusals. However, as the weeks went by, little active interest could be aroused although the town remained friendly. Later rumors began circulating attributing suspicious motives to the research team. Attendance at meetings fell off. People saw the films and then did not remain for the discussions. Finally when the interviewers returned to distribute the attitude questionnaires again and to carry out interviews they were met with tremendous hostility and anxiety climaxed by the request of the mayor that they leave town.

While the experiment failed in that it did not accomplish the researchers' aims, much valuable information and experience resulted. Based on their data, the Cummings believe the response to mental illness by the general public is (1) denial of mental illness, (2) isolation of the affected person in a hospital when illness can no longer be denied, with concomitant rationalization of this isolation with beliefs that the hospital is a wonderful place to cure people, and (3) insulation of the whole problem by a secondary denial that a problem exists.

Having delineated the nature and pattern of community response, the authors examine the functions and purposes served by these patterns. From a sociological viewpoint, society must remain in an equilibrium or it loses its integrity and ceases to be a system. A basis of this equilibrium is the predictability of behavior of the members of society. When unpredictable behavior occurs, society punishes deviants because of the threat to stability. Since the mentally ill are considered unpredictable, and since society has accepted that the sick should not be punished, society faces a dilemma which it seems to resolve through denial, isolation and insulation of the problem.

Another dilemma facing society is the role of the mentally ill person. Actually, the hospital staff and society both seek to render the patients' behavior predictable through such actions as legal commitment, locked doors, and the hospital process which often in the past has led to desocialization.

In analyzing the functions of society's pattern of response to mental illness, the authors offer some practical suggestions. They suggest that in any educational program seeking to change attitudes, it is necessary to analyze the functions served by the currently held attitudes and to deal with these realistically so that the environment is conducive to change of attitude. They suggest that a psychiatrist may not be the best person to head an educational program in the community since common expectation is that the psychiatrist is primarily a clinician, although in a hospital setting he is accepted as an educator. This experiment indicates that there may be value in training a small corps of lay people who can then serve as educators to their peers.

LUCY D. OZARIN, M.D.

THE PSYCHIATRIC HOSPITAL AS A SMALL SOCIETY by William Caudill. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts. $6.50

The past decade has seen attention focused on the organization and administration of the psychiatric hospital in relation to its therapeutic functions. In this book, Dr. Caudill, an anthropologist, reports his research in the Yale Psychiatric Institute, New Haven, Conn., a 50-bed hospital divided into two open and two closed wards. The aims of the research were:

(1) To obtain a description of the activities of the various groups in the hospital such as senior staff, residents, nurses and patients. The formal and informal structure of these groups and the interpersonal relations and communications within and between them were also studied.

(2) To trace through the hospital the actual flow of communication about events and delineation of what happened during communication in terms of clarification, distortion, omission and addition. It was felt that if the hospital is a social system, events occurring at one point will have ramifications throughout the system.

(3) To attempt to make explicit the inter-related nature of certain series of events occurring at all levels

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within the structure of the hospital. It was believed that lack of awareness of this point by those in decision-making positions contributed to problems as collective disturbances, the unanticipated consequences of administrative decisions and the seemingly inexplicable recovery or deterioration of patients.

(4) To determine whether the various sub-systems of the hospital were compatible, as for instance the degree of fit between the psychotherapeutic program and the administrative program.

These aims were carried out in three inter-related studies, namely:

(1) Direct, daily observation of the various hospital patient and staff levels and how events occurring in these levels were inter-related;

(2) The utilization of a series of pictures of hospital life (similar to the TAT) in interviewing members of all role groups to determine their perceptions of hospital life;

(3) The verbatim recording and analysis of consecutive daily administrative conferences over a period of five months.

In the analysis of his data, Caudill shows that the psychiatric hospital is, indeed, a social system which possesses significant variables which affect behavior in all areas of hospital life. Pertinent questions are raised and an attempt made to answer them. For instance, should a therapist also make administrative decisions for his patient? Caudill believes that there are some people who have the qualities to fulfill both roles though it is essential for the individual to be clear as to which role he is playing in a given instance.

The inherent instability of three-person groups and their tendency toward disturbed inter-relationships may make it possible to predict behavior in such groups.

The effect on patients of certain combinations of staff prompts Caudill to suggest consideration of how personnel are combined on shifts or on wards. He observed that different staff combinations seemed to produce different effects on social and diagnostic groupings of patients. Whether or not such planning is feasible in a large psychiatric hospital, the idea is a tantalizing one for further study. Another problem which emerged was the diversity of social class and cultures of patients and their effect on inter-patient and patient-staff relationships.

Caudill, in common with other research workers who have studied the social phenomena of the psychiatric hospital, is very much concerned with the covert emotional structure underlying the overt formal and informal structure of the hospital. He emphasizes also the need for staff to be aware of their own motivations in carrying out their roles in the hospital. Social dynamics and psychodynamics are closely related.

Caudill writes that there has been enough study of psychiatric hospitals to suggest that their organizational structure and administrative procedures are outmoded and impede the most effective use of modern knowledge. He reminds us that the present form of the psychiatric hospital has stemmed from historical circumstances rather than considerations of therapeutic goals.

There are several features of the book which deserve special mention. To carry out his study, Caudill devised his own tests and methods, for instance, the pictorial interview test and methods of coding interaction in staff conferences. These procedures are presented in detail and offer some ingenious devices to determine attitudes, perceptions and communication. They may lend themselves to predictive indicators of behavior.

The place of the anthropologist in a psychiatric setting is discussed at length. The author suggests use of the term "clinical anthropologist" and believes such social scientists can contribute in a number of ways, namely,

(1) By keeping track of the social system of the hospital and communicating findings at intervals to the staff;

(2) By participating in teaching and training programs;

(3) By assisting in planning the physical and social restructuring of the hospital and the creation of new roles for staff and patients;

(4) By assisting in hospital-community relationships;

(5) By engaging in research.

The author has chosen an effective style of writing. In each chapter he tells at the beginning what he is going to say and at the end of the chapter he summarizes what he has said. Then throughout the book there are numerous brief summaries. Since the material is quite detailed and complex, this writing style is most helpful.

LUCY D. OZARIN, M.D.

Current Studies Available

This column, to be published intermittently, will list studies and narrative reports on investigations in mental hospitals. These papers are, for the most part, too long or too technical for inclusion in MENTAL HOSPITALS.

Authors have agreed to make copies of their papers available, and requests should be sent to them directly, with 25¢ for postage and handling. The Editor wishes to point out that these studies have not been evaluated by the A.P.A.

THE NEED FOR A MULTI-DISCIPLINARY APPROACH TO CLINICAL RESEARCH: FOOTNOTE TO A DRUG STUDY. C. Scott Moss, Ph.D., Chief Psychologist, State Hospital No. 1, Fulton, Mo.

A DESCRIPTIVE STUDY OF ELECTRIC SHOCK THERAPY FROM 1944 TO 1956. Glemmer G. Wait, Research Analyst, St. Peter State Hospital, Minnesota.

THE EFFECTS OF IN-SERVICE EDUCATION UPON THE ATTITUDES OF PSYCHIATRIC AIDES. Wolf P. Wolfensberger, M.A., Geraldine Lee Joslin, R.N., Marilyn Weber, R.N., Norfolk State Hospital, Nebraska.

A STUDY OF PER DIEM COST FOR THREE CATEGORIES OF PSYCHIATRIC PATIENTS. Eleanore R. Wright, M.D., and John C. Phillips, Ph.D., Embreeville State Hospital, Penna.

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Film Reviews

Reviews of recent 16 mm films of special interest to mental hospital administrators and personnel will be prepared by the Mental Health Materials Center, film advisors to the A. P. A. Mental Hospital Service, and will appear in this space monthly.

The three new films reviewed below—BACK INTO THE SUN, BITTER WELCOME and DAVID—THE PROFILE OF A PROBLEM DRINKER—have been added to the Mental Hospital Service Film Library. Booking forms will be mailed within the next few days.

Later in the month, a complete film catalogue, containing reviews of the 17 titles now available from the M.H.S. Film Library will be sent to all U. S. subscribers.

At the Tenth Mental Hospital Institute, Mr. Alex Sareyan of the Mental Health Materials Center, will have a number of new titles to show. We are asking our subscribers to help us in the selection of new films for the library by indicating, on forms which will be provided, which titles they would like to have made available during the coming year.

BACK INTO THE SUN *(27 minutes, black & white)*

This story of a young woman who receives treatment at a day hospital has an authentic ring. The film was shot at the day hospital of the Allan Memorial Institute of Psychiatry in Montreal. No pat solution to her problem is suggested (although, as she gains increasing self-understanding, it becomes clear that she is working out a solution that may help her to function at a far lower emotional price).

But the patient's story, interesting though it is, is merely an excuse to point up the unique qualities of the day hospital. By providing a treatment program in a therapeutic environment for approximately eight hours a day, five days a week, the day hospital enables the patient to live at home the rest of the time. We are shown the range of treatments, constructive activities and relationships she experiences during the hours she spends at the hospital. Her husband brings her to the hospital after breakfast and calls for her at the end of the day. This not only enables her to live in the familiar surroundings of home, but is less upsetting to her young sons and her husband than it would be if she were hospitalized on a 24-hour basis. She is able to live a relatively normal home life without the responsibilities she is too ill to handle. Conversely, as she comes to the hospital each day, the patient brings with her experiences fresh from her life at home. In the course of her treatment during the day, she thinks and talks about these experiences and gains understanding of her feelings and behavior. In addition, these home experiences provide a sort of sounding board to measure her progress toward recovery.

Produced by the National Film Board of Canada in 1957 as one of the PERSPECTIVE television series, BACK INTO THE SUN is a straightforward and sound approach to a type of hospital service in which there is an increasing interest in this country. It could be shown to the hospital staff to demonstrate a day hospital in action, or to the lay public to show the advantages of day hospital care.

DAVID—THE PROFILE OF A PROBLEM DRINKER *(27 minutes, black & white)*

Like BACK INTO THE SUN, this film was made in Canada for the PERSPECTIVE television series, and was well-received at last year's Mental Hospital Institute. It is the dramatic portrayal of the causes and effects of liquor in the life of a young architect and his family.

Some of the reasons which may lead a person into problem drinking are analyzed. In David's case, it was shyness and lack of self-confidence. Liquor helped him to relax and "be himself" at a party, but soon he was depending upon alcohol to see him through all sorts of difficult situations. Through the help of a psychiatrist, however, David is able to evolve a plan of remedial action which points the way to an effective cure. Perhaps the film's chief value is its emphasis on the importance of recognizing the early symptoms of alcoholism—something earlier films on alcoholism have slighted. Acting and writing are of high professional calibre and the film is consistently absorbing.

This film could be shown to mental hospital staffs on all levels to explain emotional causes for alcoholism, emphasizing that it is a form of illness, and also to counteract moralistic attitudes on the part of the staff.

BITTER WELCOME *(26 minutes, black & white)*

There is a strong emotional appeal to this moving and suspenseful story of a discharged mental patient which distinguishes it from most educational films. One cannot help but sympathize with the hero, Tom Schuster, who manfully struggles, not only with his inner conflicts, but also with the hostile and ignorant attitudes he encounters when he leaves the hospital and attempts to earn a living.

It is really only one of his co-workers who is uneasy in the presence of a "psycho," but it is a part of Tom's sickness to magnify this hatred and to distrust the support of those who want him to succeed. When a dramatic crisis occurs on the job, however, he finally learns to accept friendship and also to live with the fact that there are those who will be afraid of him. The construction work setting of the film is realistic and interesting, as are the assorted characters who make up Tom's co-workers. Exceptionally moving are the scenes between the ex-patient and his loyal, but human, wife. This film should prove extremely useful to hospitals which are developing after-care programs.

BITTER WELCOME may be shown within the hospital to give nurses, social workers, aides and ancillary therapists a clearer understanding of the patient's emotional needs *after* he leaves their care so that they can help to prepare him for discharge. It will also be valuable to help the lay public understand the problems faced by the returning patient.

COMMUNICATION—THE PULSE OF THE MENTAL HOSPITAL

By THOMAS DOLGOFF, Executive Assistant, The Menninger Clinic
and IRVING SHEFFEL, Controller, The Menninger Foundation
Topeka, Kansas

"WHY DIDN'T YOU do what I wanted you to do?" is a question frequently asked by every supervisor, either aloud or silently. And "Why didn't you explain what you wanted?" is the counter-question often in the minds of subordinates. The frequency with which these questions are asked usually indicates the extent of communications failure in an organization.

Communication is a favorite topic for administrative staff meetings and national conferences, and administrators continue to search for more helpful answers to their daily communication problems. This is particularly true in psychiatric hospitals where the need for better communication has been dramatized so effectively by recent sociological studies of hospital operations.

With all this attention to the subject, why have there been so few improvements in communication practices? One major reason is that there has been more emphasis on how to distribute quantities of information than on the more important and complicated human aspects of the communication process.

In too many institutions communications continue to flow rapidly into wastebaskets and file cabinets, having little influence on the behavior and attitudes of those to whom they are addressed. Preoccupation with the formal media of communication such as manuals, bulletins, circulars, and memoranda has diverted attention from the more significant purpose of communication: to encourage all members of the staff to cooperate in achieving goals of the organization. Unfortunately, many communications tend to work against the achievement of the organization's goals by confusing and disturbing members of the staff.

Examination Before Action

A primary and continuing task of the hospital administrator is the diagnostic appraisal of his organization's communication system. Just as every individual is a unique human being who can be understood only in terms of his particular attitudes, values and background, so every organization has unique characteristics which must be taken into account in attempting to improve its communications. These include such factors as the management philosophy and atmosphere, community relationships, the cultural backgrounds of employees, and the organization's formal and informal status systems. There is no single solution to the communication problems confronting different hospitals, even when these problems appear to be identical.

In appraising an organization's formal status systems, the administrator must ask such questions as:

How can information about what is happening throughout the institution be accurately transmitted to the management group, so that policy decisions will be based on an understanding of all pertinent factors?

How can communications be used as a positive force for stimulating individual initiative and encouraging more cooperation within the group?

How can the quantity of written communications flowing through the organization be regulated so that the number is not so large as to inundate and not so small as to starve?

What can be done to reduce the number of communications that lead to misunderstanding, anger and frustration?

How can personnel working directly with patients convey an understanding of ward problems to others in the hospital who have no personal relationships with patients?

How can each member of the psychiatric team gain more understanding of what each of the other members is thinking and doing?

No study of an organization's communication system can be fruitful without an appreciation of the importance of non-verbal communication. The raising of an eyebrow or the failure to say "good morning" may be communications of greater impact than a two-page memorandum. Keeping a person waiting for thirty minutes is a communication; so is forgetting or cancelling a meeting or mispelling a colleague's name. An important executive is communicating something when, instead of waiting in his office, he comes out to his reception room to greet a visitor. Status symbols have become such a potent communication medium in industry that many large companies

have established elaborate rules governing the size of an executive's office and desk, the quality of his rug, and the type of fountain pen he uses.

A moment's reflection will suggest a variety of ways in which communication takes place in a mental hospital.

A nurse enters the doctor's office to discuss a patient. The doctor immediately tells his secretary he is not to be interrupted except for emergency calls. What is the doctor telling the nurse by this action?

The chief nurse has asked the business manager for new rugs for the patients' lounge. She has received no reply for two months. The business manager has communicated to her without saying a word.

A business manager of one hospital makes it a practice occasionally to see people where they work and invite them to discuss their problems with him. Another business manager always waits for others to take the initiative and come to his office with their problems. What messages are received by the members of the staff in each of these hospitals?

A staff physician is sitting in the superintendent's office requesting permission to attend a professional meeting. As he talks, the furrows of the superintendent's brow grow deeper and deeper.

In each of the above situations significant messages were conveyed, although the senders may have been unaware of what they were communicating or indeed that any communication had taken place.

Communication Pathology

Considerable attention has been given in management literature to communication difficulties resulting from the use of improper media, poor writing and speaking, and the failure to establish clear channels of communication both in the formal and informal organization. Without underestimating the importance of all these factors, we would like to emphasize the role of *feelings* and *attitudes* as a major factor in communication breakdowns.

A common misunderstanding about language is that its sole purpose is to convey information. As every psychiatrist knows, "factual" statements are often disguised expressions of feelings, as in the following: "I need a larger office." "I need two assistants." "The food is terrible here." "I am overworked and underpaid." "It isn't in my job description." The experienced administrator does not always accept such statements at their face value; he realizes that they may be concealed complaints about the employee's status; his work, personal problems or relationships with his supervisors.

Many communications fail because the sender does not stop to think of how his message will be received. He acts as though he were communicating with a desk or a letter tray or a robot, not with a human being. He is too often preoccupied with his own feelings and needs, and his desire to express himself; therefore, he gives little thought to the attitudes, needs and problems of the recipient and the manner in which he will react to the communication. Each individual in an organization has certain attitudes toward his work and his colleagues. He has personal goals and values, and these determine how he will interpret any message that he receives.

The manager makes a plea for more "efficiency" in the hospital. This may be viewed by the ward doctors as an order to discharge more patients, by the supply officer as an order to reduce the consumption of paper cups, and by the secretaries as an order to turn off lights.

The manager's communication did not achieve the results he desired because of his assumption that the meanings of words are clear and constant, conveying the same message to all who hear them.

A mistaken assumption of a different kind is described in the following case:

A staff nurse has done outstanding work. When a supervisory vacancy occurs, the chief nurse thinks she will surprise this nurse by announcing her promotion at a staff meeting. At the end of this meeting the staff nurse requests an interview with the chief nurse. She protests her promotion bitterly and after much discussion it becomes clear to the chief nurse for the first time that this particular staff nurse has always felt extremely uncomfortable in any kind of supervisory relationship and derives satisfaction from direct personal contacts with patients. The chief nurse has made the error of assuming that all nurses share her own goals. The individual desires of this staff nurse have not been considered.

It is surprising how frequently considerations of individual differences, which are emphasized in a doctor-patient relationship, are ignored in communications between colleagues.

The meaning of a communication is also influenced by the relationship between the persons involved. The following incidents illustrate the common tendency of subordinates to interpret a superior's question as an order or criticism.

A doctor asks an aide where he was ten minutes ago. The aide replies that he was at the canteen. The doctor says nothing more, but the aide feels he has been criticized for leaving the ward. He feels the doctor does not appreciate the unusual amount of stress he has been under that day in working with the patients. Actually, the doctor was just trying to be friendly and did not intend any criticism.

The section chief asks the nurse, "Why isn't Mr. Jones in the manual arts shop today?" This question may be interpreted by the nurse in a variety of ways, depending upon her previous relationship with this physician, her own feelings about whether she is performing her work satisfactorily and her feelings about Mr. Jones. If the nurse were asked the same question by a ward nurse on the next shift, the question would much more likely be interpreted as a simple request for information.

Misunderstandings often arise because of poor interpersonal relationships even when status differences are not involved.

A ward secretary was becoming more and more upset over what she

considered unreasonable demands by the finance office. One day she received a call from one of the finance clerks, asking her very politely to send him her time sheet. She berated the clerk for his failure to realize that she had been working overtime completing case records on some of the patients. The finance clerk was just trying to do his job to complete the pay record and was at a loss to understand her violent reaction to his request.

As messages are relayed from one person to another they tend to become distorted and abbreviated. Meanings are altered and the messages are affected by the attitudes of those who transmit them downward through the communication chain.

The superintendent asks the clinical director whether it is possible to transfer an aide from Section A to Section B. By the time this question is conveyed to the chief of Section A, it is transmitted as an order from the superintendent. There is much grumbling on Section A, not because of the loss of the aide, but because of a feeling that an order has been received which shows no consideration of Section A's problems.

The manner in which communications are distorted as they move upward through organization channels is described by Gardner and Moore:

"There is a good deal of distortion of the facts in communicating up the line. Along with a great concern for 'giving the boss what he wants,' there is a constant tendency to 'cover up', to keep the boss from knowing about the things that go wrong or the things that do not get done. No one wants to pass bad news up the line, because he feels that it reflects on him."

The examples of communication pathology which we have described illustrate some of the major causes of communication breakdown: the failure to distinguish between facts and feelings; insensitivity to the importance of personal goals and values; and the tendency to ignore the role of interpersonal relationship and status differences. The most important element in all these difficulties is the communicator's failure to ask himself this simple but essential question: "WHAT WILL MY COMMUNICATION MEAN TO THE RECIPIENT AND HOW WILL IT AFFECT HIM?"

Prophylaxis

Unfortunately for administrators and for supervisors at all levels, there are no simple, universally applicable rules for correcting the difficulties we have described. The following suggestions are therefore not offered as prescriptions which will cure all communication maladies, but rather as an approach to their prevention. It also will be apparent to the experienced administrator that no one can follow these suggestions completely and consistently at all times because of emergencies, the frequent necessity for making decisions without complete information, and the imperfections to which all human beings (even administrators) are subject.

Try Listening.

Many executives believe they are

listening when they are merely hearing. Effective listening is an active rather than a passive process. Like all successful communication, it is less a technique than an attitude. It is an attitude which conveys this message to the speaker:

"I am genuinely interested in what you have to say. I would like to help you to express yourself fully, and will therefore avoid interrupting you, even when I do not understand you completely.

"I realize that you, like all of us, must sometimes speak in metaphors, since many things cannot be stated bluntly and directly, even to ourselves.

"While listening to the words you use, I shall therefore try to sense the meanings those words have for you and to respond to your feelings as well as your words. I shall be more attentive to your feelings than to the feelings your words arouse in me."

Apart from inattentiveness and preoccupation with unrelated matters, the greatest handicap to effective listening is to say to oneself while another is speaking: "What shall I reply to this statement?" Rogers and Rothlisberger have made the following observation: "Real communication occurs . . . when we listen with understanding. What does this mean? It means to see the expressed idea and attitude from the other person's point of view, to sense how it feels to him, to achieve his frame of reference in regard to the thing he is talking about."

Test the Ice Before You Skate.

Before beginning his speech a public speaker often asks the audience if he can be heard. While this "testing" may be of obvious importance to the public speaker, its value is generally overlooked by administrators when preparing communications. Unfortunately, personnel who are responsible for issuing instructions are often too far removed from the details of day to day operations to judge the full effect of their proposals. An apparently inconsequential detail may destroy the practicability of the best conceived plan.

It is possible to determine in advance how a communication is likely to be interpreted by preparing it in "draft" form and testing it on a sample basis. This procedure can be applied effectively not only to policy statements, new procedures, forms, and other items planned for mass distribution, but also to written or oral messages intended for small groups or individuals. It is surprising how much time the testing procedure saves by reducing confusion and eliminating the need for clarifying and amending misunderstood communications.

In addition, the by-products of this approach are often more valuable than the direct benefits sought. Such informal consultations are themselves a very effective communication. They give the individuals who are going to receive the communication an opportunity to help formulate it. These consultations convey the message that their opinions are important to the organization. They may clarify the purposes of the communication and encourage enthusiastic compliance with it. Frequently, such consultations lead to a decision not to issue the communication at all, or to issue it in a modified form, or to issue it at a later date.

Train Your Carriers.

Lawrence A. Appley, President of the American Management Association, has stated: "Communication is the means whereby management gets its job done. Without it an executive is as ineffectual as a violinist without his instrument. It is a skill of management which is essential to every other management skill."

Many supervisors in psychiatric hospitals have had specific and extensive training in their particular specialty; few have had any training in the art of communication. Yet both technical and communication skills are necessary if a job is to be done properly. The administrator must depend upon his subordinates to transmit decisions and problems fully and with as little distortion as possible.

A superintendent and his department heads, after considerable study and experimentation, decided to adopt a new procedure for referring patients to occupational therapy. At the meeting where this decision was made, there was a lengthy discussion regarding the purposes of the change, its timing, and the effects this change might have on the personnel of the various departments as well as upon the patients. The superintendent knew that unless this plan were thoroughly understood by the department directors, there was likely to be considerable confusion when it was introduced, because it involved drastic changes in procedures followed by physicians, nurses and aides. The superintendent assumed that the department heads would follow his example and provide their staffs with similarly detailed explanations. Therefore, one can imagine his surprise when he heard about the complaints and confusion which he had tried so hard to avoid through meeting with the department heads. He had not trained his carriers.

Many industrial concerns have recognized that communication skill is an essential part of every supervisor's job and have invested heavily in establishing training programs in communication. Industry has learned, to its sorrow, that we cannot take it for granted that everyone knows how to communicate.

Count To Ten.

Count to ten before you send that memo—and then you may decide to tear it up. Of all communication media, the written word is the most susceptible to misunderstandings and should therefore be avoided when the message may threaten the security or status of the recipient, or is likely to arouse strong feelings for any other reason.

A business manager received the following memorandum from the superintendent: "Why has there been such a long delay in refurnishing Ward C?" The business manager was furious; he had been struggling for weeks with the supplier who had failed repeatedly to keep his delivery promises. The superintendent had dictated this memorandum hurriedly upon reaching his office that morning. He had no idea of the situation facing the business manager or of his frame of mind at the time he received the communication. The business manager was left to struggle alone with

his negative feelings until they reached a high pitch of intensity; he found himself spending the entire day framing answers in his mind to the superintendent's memorandum. It took ten seconds to dictate this memorandum but many days to undo the damage it created. Had the superintendent discussed this matter with the business manager in person, the facts would soon have become apparent.

Appley describes other advantages of verbal as compared to written communication:

". . . It may also be said, I think, that interpersonal communication through the spoken word is the highest art of communication. A man can labor over a written communication, if he wishes, until he reveals very little of himself or his true feelings; or he can delegate it completely to someone else. But face-to-face communication is quite another matter. It is something every person is called upon to do, every day of his life. Every manager is doing it more often than not in the course of his daily job. Sooner or later it reveals what he is, what he believes." *

Watch Your Timing.

It is a common observation that someone may enthusiastically accept a suggestion one day and violently reject the same suggestion on a different occasion.

Before communicating a request or an order, the administrator must assess the recipient's readiness, at that time, to understand it fully and to comply with it effectively. The administrator is often subjected to demands for immediate action. To resist such pressures, in the interests of a successful result, requires considerable self-discipline and a high tolerance for frustration. The function of the communication, as Herbert A. Simon said, is not to get something off the mind of the person transmitting it, but to get something into the mind and actions of the person receiving it.

The superintendent and the business manager had been working for many months on an improved procedure for requisitioning supplies. Just before the procedure was to be announced, the local newspapers made an unjustified "expose" of graft in the purchasing department. The superintendent and the business manager wisely decided to delay the change until the air had cleared so that the new procedure would be judged on its own merits rather than as a response to outside pressure.

A hospital administrator may listen with skill and empathy; he may test his proposals with care and train his subordinates as well as himself in the communication arts; he may be alert to the dangers of the hastily written word and may time his moves as carefully as a trapeze artist. Even when all this has been done, many of his communication problems will remain unsolved, for full communication between human beings is as rare as it is gratifying.

* *EFFECTIVE COMMUNICATION ON THE JOB, Am. Management Assoc., 1956.*

Make Him Feel at Home

By ERNEST M. SABLE

Assistant Superintendent, Business Services
The Neuropsychiatric Institute,
University of California Medical Center, Los Angeles

THE FIRST FEW DAYS of a new employee in an organization are critical in his employment life. The initial impressions which he receives and the information given to him count heavily in his later attitudes toward the job and the organization. And unless he is given a sense of "belonging" in the beginning, he is apt to be overwhelmed by the strangeness and newness of the situation.

Consequently, a hospital induction program should be directed toward making the new employee feel at home as quickly as possible. If successful, it can develop an employee who is satisfied and productive in his job, amenable to training and improvement, a positive morale influence at work, and a helpful and enlightened public relations person within the community. Failure, however, inevitably results in dissatisfaction, absenteeism, poor work, and a high labor turnover.

In order to achieve the best integration of the new worker into the organization, a four part induction program is suggested below for all new employees.

This process of course, is only a part of the total training obligation of the institution and should follow as a natural step in the recruitment, selection and placement process. Furthermore, the efficacy with which such a program works should set the stage for any further training.

The procedures outlined should minimize the effects of the usually awkward experiences of the "first day" while at the same time providing an amount of factual information which can reasonably be assimilated.

The facility of the new employee's entrance into an environment of acceptance is the shared responsibility of the personnel department and the line supervisor. Their influence will determine to a large degree the rapidity with which the newcomer meets the standards for quantity and quality, and the benefits he receives from his job training. The supervisor, realizing the individual's need to belong to a group, must also accept some responsibility for creating a climate of acceptance among the employee's future colleagues.

As the program is repeated for new groups, it should be refined and improved. Various training aids can be developed from it. For instance, making up an employee's handbook ought to be a high priority project.

An Orientation Program for New Employees

1. When the employee is hired, a staff representative of the personnel department should furnish the following information:
   a. Job description—type of work, how and why it is done.
   b. Salary and merit increases.
   c. Fringe benefits—vacation, sick leave, insurance, etc.
   d. Hours.
   e. Conditions of employment—probationary period, yearly performance reports, and standards.
   f. Opportunities.
   g. Location of work station—name of supervisor, etc.
   h. Brief explanation of the organization's structure and its program objectives.

2. The first day the new employee is on the job, his immediate supervisor should tell him:
   a. Where to report to work.
   b. To whom he should report.
   c. The location of lockers, rest rooms and bulletin boards.
   d. About eating facilities—in the institution and the community.
   e. Departmental rules and regulations.

The supervisor should also introduce him to co-workers, give him a tour of the department, explain to him his individual job, including the standards of performance expected and the use and care of machines and equipment, and also discuss plans for further training.

3. In a general orientation program for all employees, the personnel officer and the appropriate medical administrator should discuss periodically:
   a. The institution—programs and objectives, history, development, current status and future plans.
   b. Its organization—authority and responsibilities of supporting agency, duties of individual management personnel and the duties of professional people.
   c. Policies and rules—medical ethics, problems of working with mental patients, confidential nature of patient information, and regulations covering personal conduct and activities.
   d. Personnel rules and practices—rules and regulations, salary, sick leave, vacation, holidays, leave of absence, attendance, transfer, promotion, job security, retirement benefits, discipline, grievance procedure, employee organization membership, health and life insurance opportunities, educational and training facilities, merit award system, probationary period, yearly performance reports, and health and safety programs.
   e. The employee handbook and other literature as available.

4. As a follow-up program, the supervisor and the personnel department (one month after the initial indoctrination) should:
   a. Answer the employee's questions about organization policies.
   b. Repeat essential information about rules and regulations which seem to cause him trouble.
   c. Check on his initial job placement, training plans for improvement, and promotional opportunities.
   d. Check on his use of benefits—health, life and retirement insurance, educational and training opportunities, and utilization of social activities.
   e. Furnish counseling and guidance in any problems presented by the employee.

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Keeping Tab of Patients' Clothing

By LOUISE AYDELOTT, Custodian of Patients' Clothing
and JOSEPHINE KNOWLES, C.R.L., Former Registrar
Arkansas State Hospital, Little Rock, Ark.

FIVE years ago the Little Rock Unit of the Arkansas State Hospital set up a procedure for handling patients' clothes which has proved so successful that only one garment, a pair of "state" pants, has been completely and unaccountably lost—a remarkable achievement with an average daily patient census of 1,950! This procedure is the result of the combined efforts of the superintendent, the registrar, the assistant registrar and the salvage foreman, who believed that if the patients could wear their own clothing, another therapeutic goal would be reached.

The custodian of patients' clothing maintains the clothing procedure. She is responsible to the registrar and has complete charge of the marking room organization which occupies an area in the basement of one of the ward buildings. Opening on a drive, it is accessible to delivery trucks and close to the laundry and storehouse. At the present time the custodian is aided by one salaried employee, who operates the marking machine, and four patient-helpers who receive "patient pay"; one delivers packages and cleans, one does any type of hand marking, and two do clerical work.

The custodian oversees the system of handling the clothes on the ward, but has no direct control over the clothes room aides, who are employees of the nursing service assigned the responsibility of caring for the clothes on the ward.

Procedure on Admission

The clothing procedure is initiated with the making of the clothes card when the patient is admitted. On this card a record is kept of all the clothes he will use while he is in the hospital, whether private (P), state (S), or donated (D). Only one clothes card is made for each patient. It is kept in the clothes room on the ward, either in the patient's clothing bin or in a file.

Upon admission the patient is clothed in a hospital gown until physical examinations, X-ray and laboratory tests have been accomplished. His own clothes are checked and a description entered on a clothing sheet in the medical record, on the clothes card, and on a list accompanying the clothes, which are wrapped and brought to the registrar's department for delivery to the marking room. Until his own clothing is marked and returned to the ward, the patient wears state clothing which is kept, in a limited quantity, on the receiving wards.

If, or when, the patient is in good contact, he is measured by the clothes room aide, who records his measurements on his clothes card. If the patient needs more clothing—he should have at least four changes—a list of his needs is sent to the registrar's department on a special form. A letter is written in quadruplicate; the original is sent to the nearest responsible relative; the first carbon is kept by the registrar; the second carbon is sent to the custodian of patients' clothing; and the third carbon becomes a part of the patient's chart.

If clothes are not received from the relatives within a reasonable length of time, the patient is furnished with state clothes. These are ordered on the clothing requisition form and posted on the patient's clothes card. When the patient does receive private clothes, the state clothes are marked off the card in red pencil. On the mending and discard ticket a notation is made that the patient has received private clothes. The state clothes are then returned to the custodian of patients' clothing to be re-issued.

On the mending and discard ticket are recorded the discard of worn or torn clothing; clothing taken or sent home for any reason; or clothing misplaced. The information on these tickets is recorded in red on the clothes card by the custodian of patients' clothing. The discard ticket is signed by the clothes room aide, as well as by the custodian.

The custodian checks all clothing requisitions, keeps account of whether or not relatives send clothing in response to requests, does all discarding of patients' clothing, and distributes all donated clothing to the patients. (Donated clothing is fitted to the individual patient and is listed on the clothing card as D.) The custodian reports the number of packages received and the number of garments marked each month.

Marking Done Carefully

Except at Christmas, all clothing is marked before it goes to the wards. New clothing is usually checked for size before it is marked. The patient's name is put on each garment as neatly and as inconspicuously, yet as easily found as possible. Great care is exercised in the marking. On untidy and destructive wards the name and ward are marked on the garment. On better wards a clip-in laundry tag is used. This tag can be exchanged if the patient is transferred to another ward, or taken out entirely when the patient is discharged. Tags with ward numbers are kept on all the wards that use them. These are supplied by the

marking room. No clothes are used on any ward that are not processed through the marking room.

During the Christmas season (December 15 to January 2), all packages are sent intact to the patients and opened in the presence of the clothes room aide and the charge aide. They list the contents in duplicate, keep one list on the ward and send the other with the gift of clothing to the marking room for processing before the patient wears it.

The marking room uses three record books, specified as *Male, Female,* and *State,* in which are listed all clothing received. These books are kept as a permanent reference. Clothing is listed according to the source from which it is sent to be marked. Ward (W) refers to clothing listed by the ward personnel when the patient is admitted. Registrar (R.O.) refers to clothing left at the registrar's office, where name and ward are put on the outside of the package. Post office (P.O.) refers to packages received by mail and processed through the hospital mail room. The mail clerk checks the mailed packages for correct name and ward, lists the patient's name and ward, the sender's name and address in a record book. The marking room delivery man is called to collect the packages in the mail room and the registrar's department.

After the clothing is marked, the wards are called, the clothes room aides are asked to bring to the marking room the clothes cards of all patients who have received packages. When the aides arrive at the marking room, all packages are checked with the package book and signed for by the aide, and the contents put on the clothes card by the marking room employee, who notes her initials and the number and type of articles.

I.O.U. System for Transfer

When the patient is transferred to another ward, the clothes card is totaled. Any clothes that are not transferred with the patient, for any reason, are listed on an I.O.U. slip and clipped to the clothes card until the clothes catch up with patient and the I.O.U. is cleared.

A clearance slip is made for all patients who are separated from the institution whether by discharge, elopement, or death. On it is listed all clothing that is missing upon the day of separation, and the address where the possessions are to be mailed when assembled.

The clothes room aide, as mentioned before, is an employee of the nursing service, assigned to handle the clothes on the ward according to the system outlined by the custodian of patients' clothing. She may have other duties besides taking care of patients' clothing. She helps discard garments, makes requests for clothing, and handles the transfer of patients. On wards where the census is 100 or more, handling the clothing is a full-time job. On smaller wards she would be able to help with ward duties. A conscientious clothes room aide saves the institution trouble and money.

The efficient working of the clothing procedure at the Arkansas State Hospital is a testimonial to the teamwork achieved by the marking room personnel, the nursing service and the registrar's department.

Broken Windows Shed Light on Maintenance Costs

The problem of how to keep out the elements and still have a view of the outside world is a particularly difficult one in planning dormitories for feeble minded or severely retarded children. Large glass areas are inadvisable if maintenance and replacement costs are to be kept to a minimum. There are, however, some substitutes which have proven acceptable, and certain precautions which may be taken to cut down breakage.

Ideally, psychiatric screens are used to protect glass windows. However, these are often undesirable because the cost of installation is high and they give some patients a locked-in feeling. As an alternative, individual panes (preferably no more than 13" by 15") may be combined to bring the total window area up to architectural standards.

The use of plastic glass or plexiglass should be considered wherever there is a constant problem with broken glass. In one group of buildings at Myles Standish State School in Massachusetts, glass breakage has been decreased 85% by the use of plexiglass in the lower half of double hung sashes.

Where glass has been used for purely architectural design in the interiors of buildings, glass blocks might be substituted. However, where large sheets of interior glass are constantly needing to be replaced, the new polyester resin sheets with interwoven blankets of glass fibers offer a more acceptable solution.

These sheets come in a variety of weights and their impact strength and resistance to prolonged punishment is quite high. They may be obtained in a corrugated or flat style depending upon the maximum area to be covered and the maximum strength required. The initial cost of the extra heavy sheets is slightly higher than that of ¼" wire embedded polished plate glass. However, the increased life expectancy more than compensates for the cost.

Putty or glazing compound on a stub sash should be on the exterior, since it often seems to "disappear" within a short time when it is placed on the inside of the sash. The use of white lead putty should be discouraged and glazing compound used instead as this is non-toxic if eaten by the patients. It also has the functional advantage of being easier to remove when glass has to be replaced.

As an added deterrent to glass breakage, attention should be given to the sensible selection of playthings for children. Toys that are easily lifted and thrown should be made of soft plastic or other material which will not break windows upon impact. Balls, if provided at all, should be of the hollow rubber type. Careful supervision of playtime activities with these and other toys is probably the best insurance against glass breakage.

SALVATORE F. MATTA
Maintenance Foreman

GETTING THE SUPERINTENDENT'S GOAT!

A capital outlay request for six goats for Central State Hospital in Kentucky, was received recently by Commissioner H. L. McPheeters and published in the state's Department of Mental Health *Newsletter*.

Walter Fox, M.D., Superintendent of Central State, specified that five of the goats are to be Angora, female, with bright eyes. The sixth is to be a Scape, male, with sad eyes. According to Dr. Fox, the group is to have a high herd instinct, high intellect and patient orientation. The females are to be carried at Grade 13; the male at Grade 14. The animals are also to possess Caduceus horns, and those with high foreheads are preferred.

In justifying his request, Dr. Fox said:

"1. These lovable animals will replace our prison detail, keeping grounds clean of cans, old knives, axes, discarded surgical equipment, etc.

"2. These animals, organized as a herd under our Group Social Worker, will understudy our dairy herd. When the dairy herd leaves, they will be willing, after reclassification to higher grade, to participate in milk production.

"3. Angora females will be sheared for O.T. materials, wool to be made into sneakers for patients leaving grounds via new subdivision.

"4. Herd to serve as research program in extraction of Seratonin from Caduceus horns. This is reported by Division of Purchases to be found in goat horns in small quantities."

The Commissioner is studying the request and expects to act upon it shortly.

Mobile Ladder Reduces "High" Maintenance Problems

The Hastings State Hospital in Minnesota is similar to many other state institutions in that it is forced to contend with dormitory type buildings. They are three and one half stories high and present many maintenance problems. When roof repairs are necessary, or when the gutters and downspouts become dirty or clogged, it is extremely difficult to perform the necessary work with a stationary ladder.

It is a slow, hazardous task, though the actual work to be done may take only a few minutes. It necessitates constantly changing the position of the ladder, sometimes only a few feet, which is both time consuming and dangerous. When there are eight to ten downspouts on each building and a 40 foot ladder is used, the process demands that the ladder be raised and lowered at least ten times or more to accomplish the work needed on one roof.

There is always the danger of a strain or a rupture whenever an employee has to raise a forty foot extension ladder. Danger is further intensified by the possibility of the person working on the ladder over-reaching and causing the ladder to slip, rather than taking the necessary time to climb down and move the ladder the few feet needed.

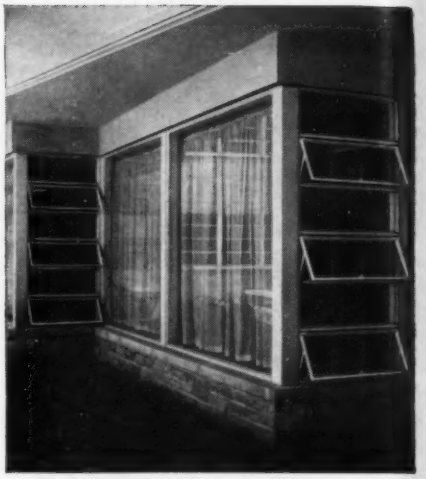
To overcome this difficulty we devised an "A" frame out of old pipe and secured it to our dump truck

and then secured the extension ladder to it, as shown in the accompanying photo. This gave us solid support for our ladder, and yet we have a very mobile unit which can be set up in places which are ordinarily very difficult to reach. By raising the dump on the truck we can put the ladder on the roof, even if there are stairways, windows, fire escapes, etc. The device may also be used to trim trees because it is not necessary for the ladder to rest on any part of the tree and the tree trimmer is able to work on outer branches or on the top of the tree without difficulty.

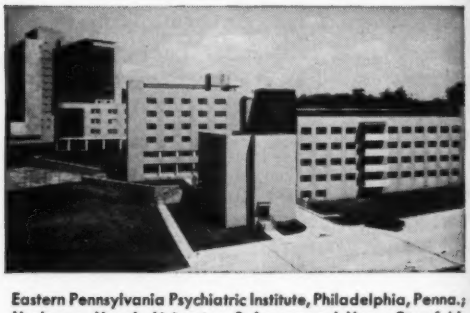
We have found the use of this device saves time and energy, is safer and can be constructed at very little expense.

JOSEPH YANZ
Building Foreman

The detention screen, used with this Truscon Intermediate Louver Window, is the principal restriction against injury and escape. Screen can be opened only by authorized use of a removable key.



These Truscon Intermediate Louver Windows offer 50% ventilation, are particularly suited to the needs of mental hospitals. A similar design provides 100% ventilation. Ventilators operate simultaneously.



Eastern Pennsylvania Psychiatric Institute, Philadelphia, Penna.; Harbeson, Hough, Livingston & Larson and Harry Sternfeld, Architects.

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apartment-like beauty with complete protection and safety

It's hard to believe from the casual, inviting appearance of these handsome Truscon Intermediate Louver Windows that they provide detention. That's because they're designed to conceal or minimize any appearance of enforced restraint. At the same time they're carefully engineered to protect mental patients against self-injury and to prevent escape.

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The degree of restraint can be entirely controlled by authorized personnel who operate the windows by a small removable crank—open or close the detention screens (above left) with a removable key.

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THE MENTAL HEALTH CENTRE AND THE CHILD GUIDANCE CLINIC
Burnaby, British Columbia

I. The Mental Health Centre

By F. E. McNAIR, M.D., Director

SIX YEARS AGO, planning was undertaken to enlarge the scope of the provincial mental health facilities in British Columbia by building larger, more modern quarters for the Child Guidance Clinic (founded by Dr. Crease in 1932) and by establishing an outpatient-day hospital department for adults. This double facility was to be built as a self-contained unit apart from the hospital at Essondale. It was to be spacious to provide for expansion, and free of institutional taint in styling and decor. It was to be a setting which maintained for the patient his status of a free, self-determining citizen.

Physical Facilities

The Mental Health Centre and Child Guidance Clinic therefore, are twin buildings joined together at one corner. They are two and a half story structures located on five acres of lawn at Burnaby, about midway between Vancouver and New Westminster, two large cities. There is parking space for about 60 cars. Each division is headed by a director, who is a psychiatrist, and there is one business manager for the combined operation.

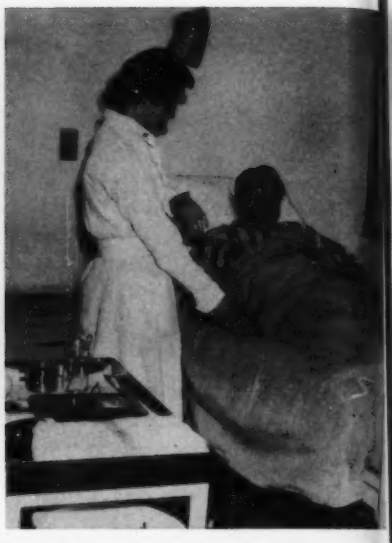
On entering the buildings one is struck by the brightness of the pastel colors decorating the walls and ceilings and the gleam of the marble toned rubber tile of the floors, patterned with rectangles of brown to shorten the linear effect of corridors. Variety has been used in the choice of colors for different rooms. Furniture is maple throughout. The use of venetian blinds and spun glass curtains is practical and lends smartness. Composition ceilings give partial sound-conditioning and lighting is adequately provided by fluorescent fixtures.

A central lecture room or auditorium, accommodating 120 persons, is shared by the Child Guidance Clinic and the Mental Health Centre. It has a separate outside entrance and can be closed off from the rest of the building to enable it to be used for evening meetings for public education in the field of mental health. A patient cafeteria accommodating 20 and a staff cafeteria accommodating 40 adjoin a central well-equipped kitchen. The cafeterias are furnished with round arborite topped tables and padded chrome chairs.

The library is located between the divisions. Spacious and separate record departments are maintained on the third floor. The receptionists communicate to the Records Department the names of patients coming in for appointment on a given day, and the appropriate files are brought down to the interview offices.

The Mental Health Centre reception desk is directly inside the door at ground level and there is an adjoining waiting room in the reception area. One proceeds around a bend in the corridor to a central somatotherapy block, flanked on one side by an ell-shaped dormitory area and on the other side by an ell-shaped activity area. The dormitory is subdivided into three four-bed

Twin buildings of Mental Health Centre and Child Guidance Clinic are joined at one corner. Common auditorium (center foreground) has separate entrance and can be closed off to provide space for public education meetings.



Above: Dr. McNair (center) and his staff evaluate new applications for admission. Attractive dormitories (none larger than four beds) and recreational therapy area provide pleasant setting for patients under treatment.

dormitories and four single rooms. The somatotherapy block contains a charting room, three physical examination rooms, and a large room where patients can be given E.C.T., each in his own bed screened off by curtains. Locker space is provided for 36 persons and locks are attached. Possessions are not left in the lockers overnight and the keys can be surrendered at the end of the day. Convention decrees that the somatotherapy unit is entered only by patients or by staff engaged in somatotherapy. There are various utility rooms in the dormitory area and an autoclave is situated in the basement.

In the activity area is a large multi-purpose occupational therapy unit, functionally divided by counters and cupboards to provide for diverse activities for men and women. Windows from ceiling to half way down the wall provide good working light. An O.T. office, washrooms, and a passage to the lawn separate this area from the recreational room where all the activities permissible in a basement rumpus room are possible. The end of the recreation room can be isolated by a folding door for group meetings of patients or staff.

The procedural services of laboratory, physiotherapy and E.E.G. together with the neurologist's office are grouped around a second waiting room in the corner of the somatotherapy unit most distant from the receptionist.

From the reception desk, one can proceed directly upstairs to the second floor where the offices are located. The Director's office is at the top of the stairs and his secretary serves as a secondary receptionist. Adjacent to her office is a waiting room for people with appointments.

There are 48 offices on the second floor on both sides of a corridor which forms the periphery of a quadrangle; the central patio is open to the sky and on dry days provides an extra area which is private from the outside world. The offices of each professional group are congregated together and there are adjacent conference rooms for staff meetings.

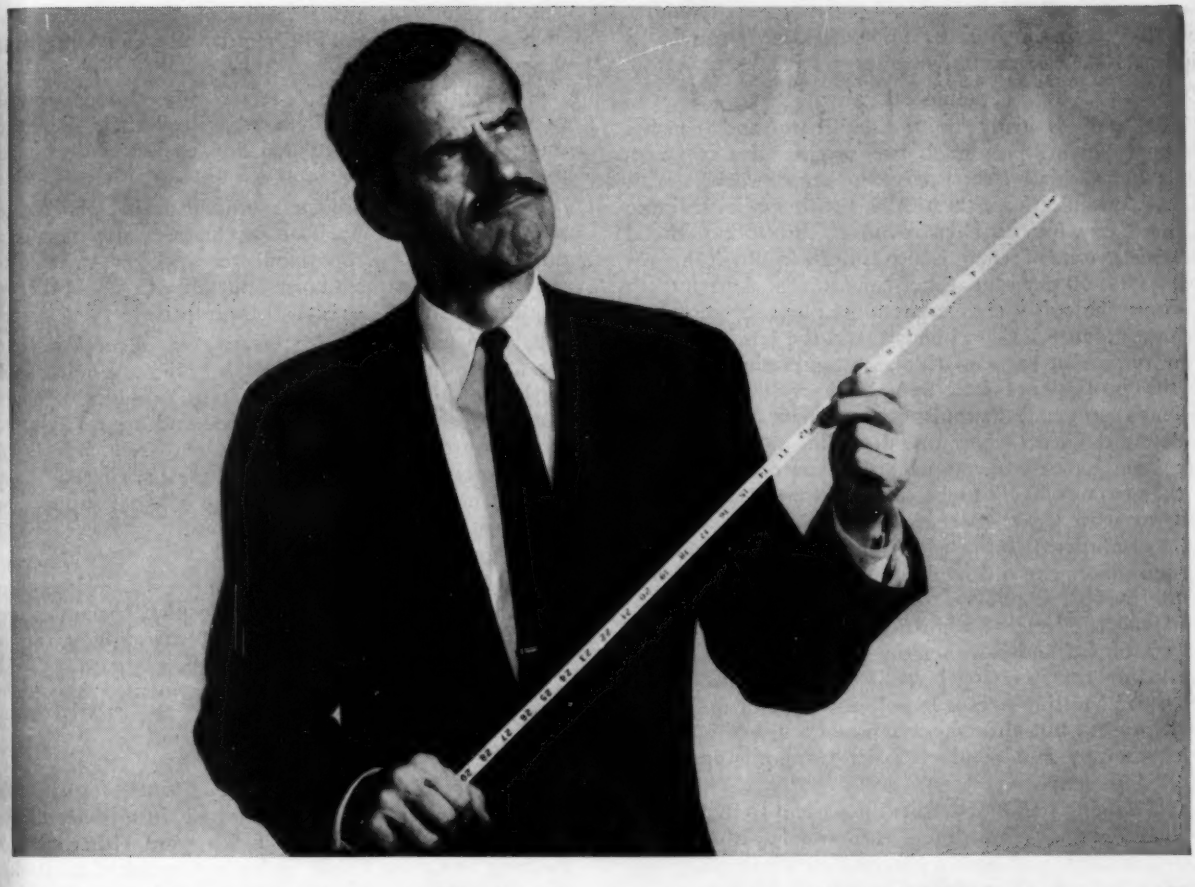
Treatment Program

There are four criteria for admission:

1. Voluntary attendance. 2. Residence within an hour and a half travel distance. 3. Ability to function in the community without 24 hour supervision. 4. No other psychiatric treatment being given concurrently.

The patient's first contact with the Mental Health Centre is for consultation only and medical referral is required. All cases receiving treatment, whether intensive or minimal service, are evaluated first, so that goals of treatment are clearly established and appropriate to the service the patient requires and can use. It cannot be assumed that because a patient still has problems to work out, he will want to work them out and participate in voluntary follow-up care in the form of psychotherapy or casework.

No waiting list has been allowed to accumulate. Over 50 patients have been evaluated each month, and about half of these have been accepted for treatment. With



How does the public measure healthfulness?

When judging healthfulness or the sanitation of an area, the layman depends on his eyes and nose. Even if an area looks clean he will be suspicious if a noticeable "cover-up" odor is present. Strong chemicals used to smother institutional odors may only disturb a patient, annoy a visitor and probably make the work of your staff more difficult.

Modern cleaning and sanitation systems, such as those developed by Airkem, include a combination of interrelated products to comfort the patient, assure the visitor and make the cleaning task easier. Airkem "A-3," for example, penetrates and cleans out dirt where soap and scrubbing cannot. It effectively combats the dangers of cross infection, kills odors on the surfaces and in the air and leaves a clean, air-freshened effect. This unusual combination of properties results from a unique formulation. Airkem "A-3" combines a non-ionic, synthetic detergent, a quaternary ammonium sanitizer, an organic chelating agent and Airkem odor counteractants.

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ened effect to indoor air. Through their proper use, a hospital can control even a serious odor condition without resorting to heavy chemical smells or adding perfume overtones to the air.

Airkem systems are instrumental in maintaining a healthful, enjoyable environment in hospitals throughout the U.S.A. Perhaps your institution, too, can use this system of products to advantage. An Airkem representative is always available at your convenience to demonstrate how these unique products can assist you.

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the present staff, 75 cases can be assessed each month, and the maximum number under treatment can be as high as 160. The monthly turnover is 25.

Staffing Pattern

The staff is truly multi-disciplinary and consists of the following personnel: two psychiatrists, two residents in psychiatry, six psychiatric social workers with M.S.W. qualifications, three R.N.'s with special training in psychiatry, four psychiatric nurses, three occupational therapists, (one of whom is also trained in physiotherapy and spends 50 per cent of her time in that department), three psychologists, six clerk-stenographers, a laboratory technician, an E.E.G. technician, and the janitorial staff.

Every patient has a psychiatric examination. Any one of the professional staff may be assigned to be the patient's principal therapist but we have endeavoured to define the areas where one discipline rather than another may have more competence Casework by a social worker is most likely to be directed toward supporting patients with weak egos, assisting social adaptation in the community, helping with practical matters concerning job placement and family relationships, contributing to the over-all evaluation of a patient's assets and liabilities at the time of admission, determining readiness for treatment, and assisting the patient in focusing his motivation for receiving help. The psychologist carries out mental testing and is largely involved in the assessment process, but also takes charge of a group in group psychotherapy and conducts brief psychotherapy with selected patients.

The nursing staff first orients the patient to the various facilities, explains how the Centre works, what is expected of him, and how he should go about using the services offered. The nurse therefore, becomes very closely associated with the patient and is often the person to whom he turns when his doctor or caseworker is not readily available. It is considered that the first claim on the nurse is to take time with the patients. Hence, an effort is made to reduce the number of her administrative activities and superfluous charting.

The charge nurse is the hub of therapeutic activity. She sees to it that the demands of various therapists for a patient's time do not conflict. She monitors the day to day progress of the patient and usually takes the initiative in posting a patient for staff conferences. There is a public health nurse for the outpatient department as well as a charge nurse for the day hospital, so that the outpatient too may have a feeling of group support and group identification similar to that experienced in the day hospital.

Summary of Services Offered

1. Interview psychotherapy to improve a patient's social integration and adaptation at the point of discharge from hospital; or to prevent his hospital admission. He can be working and otherwise fitting into the community life while reporting for regular appointments. About one-fifth of the outpatients have been recently discharged from the hospital.

2. Intensive casework service where social factors need to be worked out in order to make social adaptation or rehabilitation a success.

3. Somatotherapeutic measures on a maintenance basis such as periodic E.C.T. or regular use of tranquilizing drugs.

4. A minimal supportive service offered once monthly in the evening for patients who need their dosage of tranquilizing drugs regulated and checks made on any toxic symptoms.

5. Day hospital care for a limited period of time for patients referred by private psychiatrists, and requiring milieu therapy, occupational therapy and/or somatotherapy to make them more amenable to psychotherapy in subsequent office visits to their private psychiatrists.

6. A social club, which meets every second week at the Centre in the evening and is under the joint sponsorship of patients and staff. This provides a transition between the treatment process and a total reassimilation into community life. The club is a vehicle for social integration and provides a means whereby social support may supplant the use of medicinal support for outpatients requiring long-term care.

The somatotherapy unit is used for Day Hospital patients and outpatients together but the area designated for social therapy is for the Day Hospital patients alone. It is felt that a satisfactory therapeutic milieu can be maintained only if the group attending from day to day is kept relatively intact, and not fragmented by persons who attend casually.

Operating Policies

Before the Mental Health Centre opened, four months of planning and preparation went into determining policy. Various department heads were either already working at Crease Clinic or became attached to it during that period, and meetings were held each week. Before the actual opening of the building, top staff moved in to the premises for a period of two weeks in order to prepare the unit.

Policy meetings of department heads are now held weekly and each department also meets weekly. Progress conferences on patients already under treatment are held in three one-hour periods during the week, and at these times the whole staff assembles to discuss treatment policy.

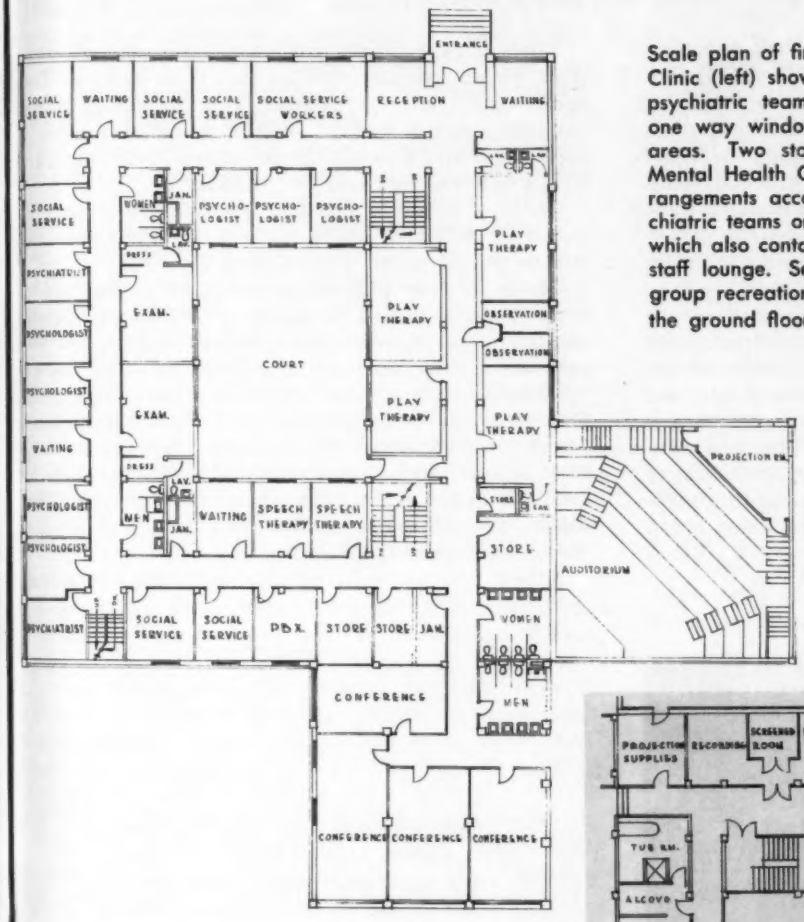
Assessments of new cases are conducted two afternoons a week and, in the final hour of these afternoons, the staff meets to discuss the cases to determine what disposition should be made of them.

A unit file is kept. All staff members dictate their records on dictating machines strategically located. Narrative notes are typed out as received and pasted on the narrative sheets in time sequence for better communication between staff members.

Cross referrals may occur between the Mental Health Centre and the Child Guidance Clinic and when this occurs, staff conferences are held between the two divisions.

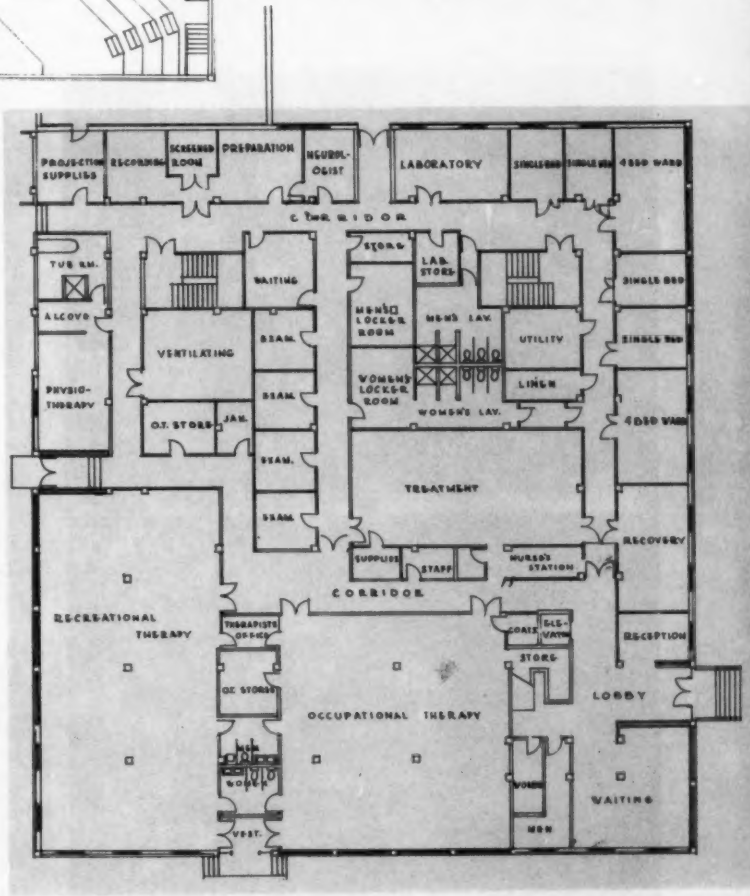
The staffs of both units are given every encouragement to mix socially during the noon hour and in any social occasions planned for the evening. A very happy informal spirit of comradeship has developed between the staffs at all levels.

Selected Floor Plans of
MENTAL HEALTH CENTRE and CHILD GUIDANCE CLINIC



Scale plan of first floor of Child Guidance Clinic (left) shows typical office layout for psychiatric teams; observation rooms with one way windows adjoining play therapy areas. Two story auditorium also serves Mental Health Centre. Duplicate office arrangements accommodate three more psychiatric teams on second floor (not shown), which also contains library, steno-pool, and staff lounge. Service areas and space for group recreational therapy are located on the ground floor.

Scale for both plans is 1/32" = 1' 0".



Ground floor of two and one-half story Mental Health Centre (right) contains somatotherapy block flanked by dormitory and activity areas. First floor (not shown) contains offices. Steno-pool and student lounge are on the top level.

Note: The juxtaposition of the plans above and at right indicates where the buildings adjoin. However, different floors were selected to illustrate main functions in each facility.

II. The Child Guidance Clinic

By U. P. BYRNE, M.D., Medical Director

THE BURNABY CHILD GUIDANCE CLINIC, a quadrangular shaped building adjacent to the Mental Health Centre, is the headquarters for the administration of the Provincial Child Guidance Clinics. Here is located a group of offices for the Director of Clinics, the Chief Psychologist, the Supervisor of Psychiatric Social Work and the Senior Public Health Nurse. Adjoining these are the central secretarial offices. The senior stenographer's office is a glass enclosed partition in the northeast corner of the main office.

The appointment controller has a separate office with double telephone service where all appointments for patients and staff are arranged. The remainder of the building itself is used by the various teams making up the Burnaby and mainland traveling clinics.

Just inside the entrance door of the clinic is a waiting room with seating accommodations for seven. There is a toilet room adjoining. Across the hall is the receptionist, who is also in charge of the in-and-out board for the staff and the phonograph and call system which is wired to all waiting rooms and staff lounges.

There is space for six psychiatric teams, three on each floor, with a separate office for each team member. Each team consists of a psychiatrist, two psychologists, four psychiatric social workers, (one of whom is a casework supervisor) and a public health nurse. Each team area has its own waiting room for patients.

One-way windows and tape recording machines between psychologists' offices are used for the supervision and tuition of junior psychologists.

There are four physical examination rooms, two on each floor. Each has a separate toilet and dressing cubicle. Four playrooms are grouped on the main floor and two of these have ceiling microphones and one-way windows with an adjacent observation room containing tape recording equipment and fixed upholstered stools for nine observers and the supervisor. Toilets are adjacent to the observation-playrooms. Each playroom has a double locker, a sink, a blackboard, a bulletin board, rubber covered walls, rubber tiled floor and acoustic tile on the upper walls and ceiling.

Adjacent to the suite of playrooms are two storage

Each psychiatric suite has its own waiting room (left). Physical examination (below) and psychiatric interview (lower left) are part of admission procedure. Special games and toys facilitate communications between child and therapist.

rooms for toys, and finger painting equipment. These are also used for drying finger paintings. Other storage rooms are provided for psychological equipment and office supplies.

There are four conference rooms, each with a seating capacity of 20 around a large sectional table. These are also used for lectures to small groups.

The speech therapists' suite consists of an office and a suitably equipped treatment room.

In the basement there is a large group therapy room with piano, phonograph, table tennis gear, lounge chairs, etc. A storage room and toilets are attached. Also on this floor are staff showers and a separate room for special staff activities.

At ground level with a separate entrance is the auditorium suite consisting of a spacious rotunda with toilets adjacent, and a banked lecture room with accommodation for 120. There is a small stage and a storage room in the front of the auditorium; and a projection booth in the rear. The projection booth is fitted with a 16 mm. sound movie projector and a projector for varying size slides. On the floor in front of the stage there is an epidiascope for showing charts, pages from books and other printed material. The projection booth and the stage are interwired for sound with microphones in both areas.

Facilities for staff consist of a general common room with an auxiliary common room across the hall. A rest room is provided for female staff and a smaller rest room for male staff. The general common room is equipped with an electric refrigerator, hotplate, and two-compartment sink with storage space above and below. Both common rooms are furnished with chesterfields, tables and leather upholstered chairs. The female rest room is provided with a couch. In the center of the building there is a tiled quadrangle for staff use. This is equipped with two large umbrella tables, numerous collapsible chairs and six adjustable lounge chairs.

On the lawn surrounding the building is a covered play area with an adjacent shed for storage of outside play equipment.

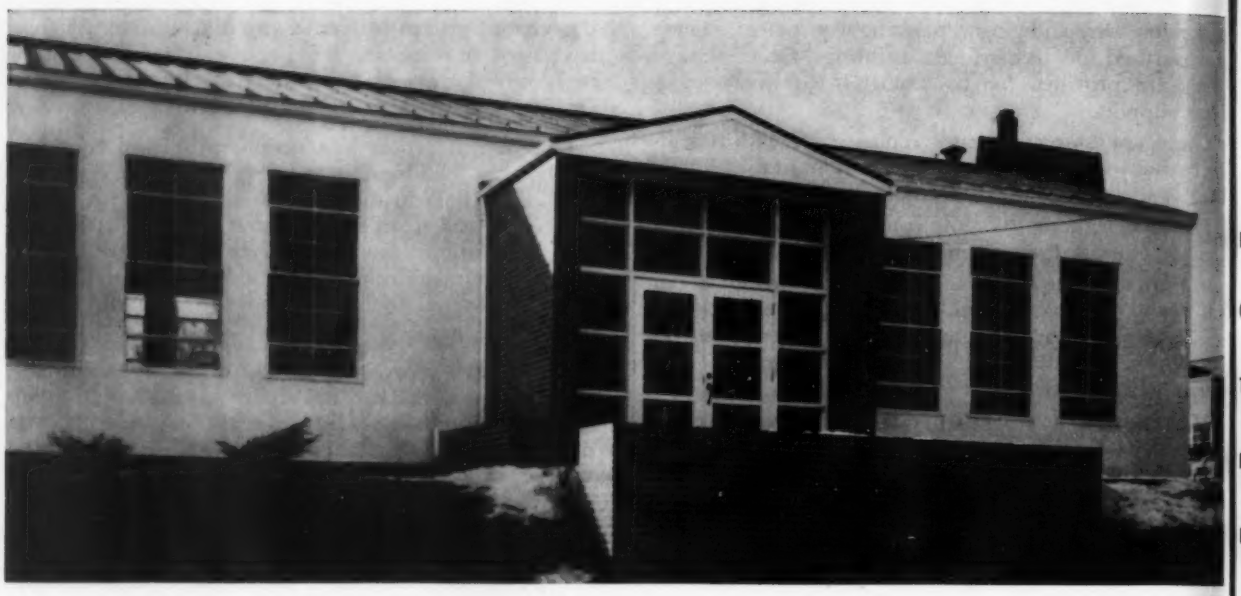
The Burnaby Clinic, in addition to providing for the diagnosis and treatment of children in the greater Vancouver area, is the administrative centre for Child Guidance services in the Province of British Columbia. This is a vast, sparsely settled area extending from the Yukon in the north to the American border, and from the Rockies in the east, out to the Pacific. It is larger than Washington, Oregon and California combined, with a population less than Washington's. There is a permanent clinic in Victoria for the capital of the province and other points on Vancouver Island, and our traveling clinic visits all the large towns in the province at least once a year. An increasing demand for these services may make the establishment of other permanent clinics necessary in the interior valleys.

As with so many other clinics, ours was formed to help with children who were problems to child caring agencies and in difficulty with the juvenile courts, and our conference rooms are still used daily by members of the various groups interested in child welfare. As time has passed an increasing number of children are referred by family doctors or by parents themselves and these "private" cases now occupy most of our time.

Our annual report lists various problems, from the psychoses of children to transient behaviour disorders. The clinics help in the selection of children for special schools for the retarded, defectives, the blind, the deaf and the spastic in the province. As yet we have no residential treatment centre for children and much time and thought has to be given to less satisfactory alternatives.

The clinic serves as the centre for mental health education. Each month medical students, nurses in training or those taking post-graduate courses, and students from the Department of Education and the School of Social Work, attend the Clinic for varying periods. The University of British Columbia places post-graduate students here who undertake various research projects. Our library is one of the best in the province for books devoted to the problems of childhood. The auditorium is used for staff lectures to local groups interested in mental hygiene.

The building is providing an excellent meeting place for those of every profession interested in planning more adequately for the emotional development of children.

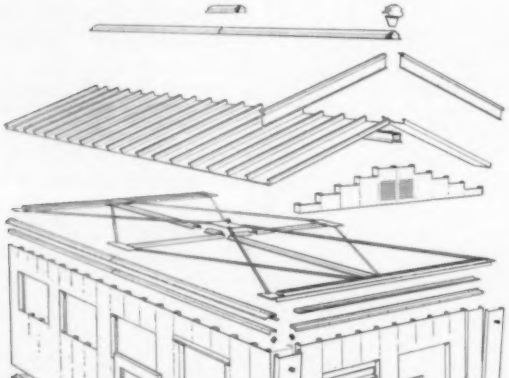


Prefabricated Construction Solves Budget Problem

By A. NEAL DEAVER

Administrator, Independence Sanitarium and Hospital
Independence, Missouri

WE HAVE RECENTLY completed a new recreation building and auditorium for our School of Nursing at a cost of only $39,000. Our budget could not meet the cost of a conventional type of structure such as brick or stone, but after looking into the prefabricated steel construction, we found we could get an attractive, thoroughly modern building at a cost well within our financial limits.



Exploded view of a typical Steelox building assembly.

We chose an Armco steel building of Steelox (steel paneled) construction with a floor area of about 3600 square feet which will give good service. At the rear of the auditorium is a 20′ by 24′ ell-shaped annex which serves as a nutrition laboratory for the school and as a kitchen for special occasions, such as staff dinners.

The auditorium itself seats 300 persons and has a stage 20′ by 36′. It also doubles as our major banquet hall. There are washrooms and coat checking facilities, dressing rooms offstage, and a public address system.

The building is acoustically treated throughout and is lighted by ten gymnasium type lamps. It is heated by hot air circulated overhead to outlet ducts around the walls at floor level. The exterior finish is Pittsburgh paint applied directly to the steel panels. Interior finish is 4′ by 8′ gypsum board over 2″ fiberglass insulation. This is covered by ¾″ fiberglass acoustical block in the ceiling area.

The cost of this prefabricated steel building as quoted above is complete. Basic construction was done on a contract plus basis with the exception of the interior finish, which was done by hospital personnel.

Photos: Armco Drainage & Metal Products, Inc.

PROGRAM TOPICS AND LEADERS FOR TENTH MENTAL HOSPITAL INSTITUTE

October 20th through October 23rd, 1958
Hotel Muehlebach, Kansas City, Missouri

PERSONNEL NEEDS ARE CHANGING
Howard P. Rome, M.D., Rochester, Minn.

ORGANIZING TO MEET NEW PERSONNEL NEEDS
H. L. McPheeters, M.D., Louisville, Ky.

TRAINING OF WARD PERSONNEL
Tirzah M. Morgan, R.N., Md. and Martha Gibson, Ind.

FULL UTILIZATION OF ANCILLARY PERSONNEL
David W. Harris, M.D., D. C. and Donald C. Pritchard, Ark.

RECRUITING AND RETAINING PERSONNEL
T. Glyne Williams, M.D., Conn. and David Zaron, N. Y.

VOCATIONAL REHABILITATION IN THE MENTAL HOSPITAL
Harold R. Martin, M.D., Neb.

ACADEMIC LECTURE:
PSYCHOLOGICAL SPACE MEDICINE
Captain Norman Lee Barr, M.D., U. S. Navy, Washington, D. C.

PSYCHOANALYTIC CONTRIBUTIONS TO TREATMENT PROGRAMS IN MENTAL HOSPITALS
Alfred Paul Bay, M.D., Kansas

MENTAL ILLNESS AND PREPAYMENT INSURANCE PLANS
C. A. Roberts, M.D., Montreal and a Blue Cross representative

THE MENTALLY RETARDED—A COMMUNITY RESPONSIBILITY
Peter W. Bowman, M.D., Maine

RECENT DEVELOPMENTS IN THE TREATMENT OF ALCOHOLISM
Merrit W. Foster, Jr., M.D., Va.

ADMINISTRATION OF THE HOSPITAL PHARMACY
Glen J. Sperandio, Ph.D., Ind.

APPLICATION OF RESEARCH FINDINGS TO THE HOSPITALIZED EPILEPTC
Melvin D. Yahr, M.D., N. Y.

HOUSEKEEPING PROBLEMS OF THE MENTAL HOSPITAL
Helen K. Johnson, Kansas

ADMINISTRATIVE CONTROLS OF MATERIAL
Alexis Tarumianz, Del.

NEW FRONTIERS IN THE MENTAL HEALTH EFFORT
Dale C. Cameron, M.D., Minn.

ADAPTATION OF OLD BUILDINGS TO NEW NEEDS
Leader to be announced

INTENSIVE TREATMENT OF THE SENILE PSYCHOTIC
Robert C. Hunt, M.D., N. Y.

The closing date for pre-Institute enrollments is September 25th. The Hotel Muehlebach will confirm all hotel reservations as they are received.

Institute Highlights

Early Institute reservations are essential this year because the American Royal Livestock Show is being held in Kansas City during the same week. Those who return to work after Labor Day are urged to return the green slips to M.H.S. and the postcards to the Hotel Muehlebach as quickly as possible, to ensure hotel reservations.

This year we are honored to have Captain Norman Lee Barr, Medical Corps, U. S. Navy, and Project Director for Research Astronautical Medicine, as our Academic Lecturer. Dr. Barr's subject will be "PSYCHOLOGICAL SPACE MEDICINE."

An innovation this year will be the announcement as well as the presentation of the A.P.A.-M.H.S. Achievement Awards. Dr. Mathew Ross, Medical Director of the A.P.A., will present the Awards and Honorable Mention Certificates to the winners at the Annual Dinner on Monday evening.

In addition to the Program Topics listed on this page, there are a number of optional meetings. The Business Managers and Directors of Volunteers will hold their respective meetings at 1 p.m. on Sunday. On Monday the Southern Regional Education Board has a meeting at 4:15 p.m. and on Tuesday, the Interstate Compact on Mental Health will meet at 4:10 p.m.

On Saturday, October 18, the first workshop for Commissioners and/or Directors of State Mental Health and Hospital Programs will be held from 9 a.m. to 6 p.m., followed by dinner.

The usual informal party will be held on Tuesday evening, and on the same evening, there will be an informal, optional gathering of Commissioners of Mental Health (not to be confused with the day-long Saturday workshop).

Dr. William Roth has resigned his co-chairmanship of the Local Arrangements Committee in favor of Dr. Donald G. Greaves, who has succeeded him as Head of the Department of Psychiatry at the University of Kansas Medical Center. Dr. Roth will, however, remain as one of the most active committee members. Dr. Greaves shares the co-chairmanship with Dr. G. Wilse Robinson, Jr., a long-time friend of M.H.S.

Time Out From a Holiday!

Patients from Muscatatuck State School in Butlerville, Ind., take time out from their tour of Washington, D. C., for a short rest and a chat with Roy Sievers and Albie Pearson of the Washington Senators baseball team. Unfortunately, the ball game where they were to be guests of the Washington Lions Club was rained out, but fair weather prevailed throughout most of their six-day sightseeing trip to Washington and New York City. They visited the White House, Congressman Earl Wilson of Indiana, the U.N. Building and the Bowery, along with other points of interest. This was the fourth group from the school to make the annual tour under the sponsorship of the Lions Clubs of Southern Indiana (District 25-F).

People & Places

ILLINOIS: **Mr. Robert H. Klein,** a Consultant to M.H.S., was recently honored by the U. of Chicago for his work as chairman of the building committee of the board of directors of Michael Reese Hospital where he played an important part in the expansion of the hospital and the redevelopment of that neighborhood. . . . **Dr. John J. Wooster** is now assistant medical superintendent of Manteno state hospital. KANSAS: **Mr. Eugene J. Pawl** has been promoted to the position of business manager at Topeka state hospital. He replaces **Mr. Ralph E. Young** who died in April. . . . **Dr. Saul Siegel** was appointed chief psychologist, also at Topeka state hospital. . . . KENTUCKY: Commissioner McPheeters has appointed **Dr. Wilber A. Mitchell** director of the community services division of the department of mental health. On September 1, **Mr. Maurice L. Kohnhorst** became psychiatric social work consultant of the department replacing **Miss Dana L. Ingle.** She resigned to take postgraduate work at Western Reserve University in Cleveland. . . . **Dr. Harold William,** the new director of professional services of the department, will also act as assistant commissioner. MINNESOTA: The citizens of Fergus Falls recently celebrated Dr. Patterson Day in recognition of the outstanding contribution made by **Dr. W. L. Patterson** to the mental health program of the state. Dr. Patterson has been a member of Fergus Falls state hospital for 46 years, serving as superintendent for many years. . . . **Dr. Robert B. May** has been appointed clinical director at Fergus Falls state hospital. . . . The new superintendent at Hastings state hospital is **Dr. John H. Reitman,** former superintendent at Anoka state hospital.

HERE AND THERE: The name of **Mary E. Corcoran,** formerly associate technical advisor in psychiatric nursing with the U.S.P.H.S., has been given to a children's ward at Sonoma State Hospital in Eldridge, Calif. in recognition of the valued consultation service given to the hospital by Miss Corcoran. . . . **Dr. James V. Lowry** has been appointed Chief of the Bureau of Medical Services of the U.S.P.H.S. He succeeds **Dr. John W. Cronin** who died in March. The Bureau of Medical Services administers the Public Health Service Hospitals, the Indian Health Service, Foreign Quarantine, the Hospital Survey and Construction Program, and research activities concerned with the nation's dental and nursing resources. . . . A two million dollar building program was started in June by St. Vincent's Hospital of Westchester County, New York, with the breaking of ground for a four-story structure to be called **"The Cardinal Spellman Pavilion."** This building, to be completed in 1959, will have a bed capacity of 105 and will permit the expansion of services for both inpatients and outpatients and the inauguration of such services as a day hospital and a children's observation unit. . . . **Dr. Richard Lilly** is now superintendent of the Weston, W. Va., state hospital and **Dr. Preston E. Harrison,** acting superintendent of Big Spring, Tex., state hospital. Both have recently completed the Menninger Foundation training program. . . . Pennsylvania has a new commissioner of Mental Health: **Dr. John E. Davis.** He replaced **Dr. Robert A. Matthews** who became full time professor of psychiatry at Jefferson Medical School in Philadelphia. Dr. Evelyn R. Reichenbach, clinical director at St. Elizabeths hospital, Washington, D. C., has been promoted to First Assistant Physician, position left vacant by the death of Dr. Jay L. Hoffman in May 1957. She will be replaced by Dr. Manson B. Pettit.

You Can Hear It Now

For the many who had to stay home and mind the store instead of attending the 114th Annual Meeting in San Francisco, Audio-Digest, a non-profit subsidiary of the California Medical Association, has recorded the highlights of important papers.

These hour-long magnetic tape recordings, pertaining to institutional, clinical and research developments, are now being distributed to superintendents and managers of state and VA hospitals, to commissioners of mental health and other psychiatrists. With the tape recording will come posters for the hospital bulletin board and an index of the papers presented.

The project was sponsored by the Mental Health Education Unit of the Smith, Kline and French Laboratories. If the tapes prove to be popular as a training and information aid, the A.P.A. Mental Hospital Service will start negotiations to obtain similar recordings of selected meetings and seminars as an additional service to its members.

Quarterly Professional Calendar

A.P.A. ANNUAL MEETING
1959 April 26-May 1st. Municipal Auditorium, Philadelphia
1960 May 9-13, Convention Hall, Atlantic City

A.P.A. MENTAL HOSPITAL INSTITUTE
1958 Oct. 20-23, Hotel Muehlebach, Kansas City, Mo.
1959 Oct. 19-22, Statler Hotel, Buffalo, N.Y.

Other Meetings, October, November, December, 1958:

INSTITUTE ON CHRONIC SCHIZOPHRENIA AND HOSPITAL TREATMENT PROGRAMS, Oct. 1, 2, and 3, Osawatomie State Hospital, Kan. No registration fee.

CENTRAL NEUROPSYCHIATRIC ASSOCIATION, Oct. 17-18, Columbus, Ohio.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, 3rd week of October, New York, N.Y.

AMERICAN PUBLIC HEALTH ASSOCIATION, Oct. 27-31, St. Louis, Mo.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Nov. 17-22, Kansas City, Mo.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, Dec. 15-16, New York, N. Y.

Remotivation Team Visits Rhode Island State Hospital

The first Remotivation Training Team, consisting of Mr. Leslie Richards, R.N., assistant director of nursing, and Mr. Walter Pullinger, psychiatric aide, both of Philadelphia State Hospital, will give its first course (five working days) at the Rhode Island State Hospital for Mental Diseases at Cranston during the last week in August. This hospital was chosen for the first visit because of its similarity to Remotivation's parent hospital, Philadelphia State.

Next on the list will be Augusta State Hospital in Maine, followed closely by hospitals in New Hampshire, New York and New Jersey. Wisconsin, Michigan, Ohio, Iowa, Indiana and Kentucky are scheduled to have a training team in the Fall.

Nearly thirty states have asked the Smith, Kline and French Foundation Remotivation Project for training teams and have designated one hospital as a training center. Letters continue to come in daily from commissioners, nursing consultants and others asking about the program. Some 56 prints of the film "Remotivation—a New Technique for the Psychiatric Aide" and the accompanying manual have been sent out on request.

The five-day course is designed to open with one day of orientation by the nurse member of the Training Team, mainly for the hospital's director of nursing, head of nursing service, director of nursing eduction and as many as possible of the medical administration staff. Instruction in the actual technique is to be given by the psychiatric aide during the next four days. Instruction will consist of lectures, demonstration and practice.

Because of the difficulty in sending a training team immediately to all the hospitals which have requested one, Dr. Eugene Sielke, Superintendent of the Philadelphia State Hospital, offers to play host to any director of nursing or other administrative personnel from hospitals which are not yet scheduled for a visit by a training team. The Philadelphia State Hospital can feed and house such visitors but cannot pay travel expenses.

Requests for the film, training manual or a training team should be sent to Dr. Robert S. Garber, Chairman, Smith, Kline and French Remotivation Project, Box 7929, Philadelphia 1, Pennsylvania.

Commissioners' Workshop To Precede Tenth Institute

A one-day workshop for Commissioners and/or Directors of State Mental Health and Hospital Programs is scheduled to take place on Saturday, October 18th, at the Hotel Muehlebach, Kansas City, Missouri, immediately before the opening of the Tenth Mental Hospital Institute.

The purpose of the workshop is to appraise economic factors underlying mental health and hospital planning and to explore ways of making the most effective use of existing resources. Should this meeting, which is the first of its kind, serve the Commissioners usefully, it may set a pattern for a similar meeting every year, to coincide with the Mental Hospital Institutes.

The Mental Health Education Unit of the Smith, Kline and French Laboratories has generously made a grant to defray the expenses of this first Commissioners' Workshop. Dr. Mathew Ross, Medical Director of the A.P.A., will be the general chairman of the workshop.

for depression

▲Deprol▲†

Clinically confirmed in over 1,200 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation

► restores natural sleep

► reduces depressive rumination and crying

► often makes electroshock unnecessary

Alexander reports 57% recovery within an average of eight weeks.[1]

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function

► causes no excessive elation

► produces no liver toxicity

► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE-MARK

Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N.J.*

Clinical excerpts

Use of meprobamate in chronic psychiatric patients

No. 5 of a series

Meprobamate brought symptomatic relief to 105 of 145 psychiatric patients "representative of the entire hospital population," 70 of whom obtained pronounced to moderate relief.*[1]

1. Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Emotional disorders treated with meprobamate and promazine. Connecticut M. J. 21:1047, Dec. 1957.

SYMPTOMATIC IMPROVEMENT

(hospitalized patients—all types)

by disease

DIAGNOSIS	NO. OF PATIENTS	NO. IMPROVED
SCHIZOPHRENIA		
PARANOID	7	2
NON-PARANOID	45	34
DEPRESSION		
PSYCHOTIC†	37	25
NEUROTIC	16	10
ANXIETY STATE	9	8
CHARACTER DISORDERS	15	13
OTHERS	16	13
TOTALS	145	105

by symptom

SYMPTOM	NO. IMPROVED
SLEEP DISTURBANCES	36
ANXIETY	30
TENSION	31
AGITATION	8
OTHERS	11
TOTAL	116

†Relief mainly in symptoms of anxiety, tension and insomnia.

*Miltown®

the original meprobamate

discovered and introduced by

WALLACE LABORATORIES
New Brunswick, N. J.

• alleviates anxiety in chronic psychiatric patients • facilitates psychotherapeutic rapport • improves disturbed ward behavior • suitable for prolonged therapy • no liver or renal toxicity reported • free of autonomic effects.

CM 6000